27621

NATIONAL LIBRARY
OTTAWA

CANADA

BIBLIOTHÈQUE NATIONALE
OTTAWA

NAME OF AUTHOR.....JOAN....BROCKMAN...............

TITLE OF THESIS....ARE...ATTITUDES...TOWARD..
....THE...MENTALLY ILL CHANGING?
..A RETURN...TO THE...BASELINE TOWNS

UNIVERSITY........ALBERTA.............................

DEGREE FOR WHICH THESIS WAS PRESENTED.....M. A...........

YEAR THIS DEGREE GRANTED.......1976......................

Permission is hereby granted to THE NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

(Signed)...Joan Brockman...

PERMANENT ADDRESS:

....DEPT...OF SOC....
....EDMONTON, Alta.
....

DATED April 14...........1976

NL-91 (10-68)

INFORMATION TO USERS

THIS DISSERTATION HAS BEEN MICROFILMED EXACTLY AS RECEIVED

This copy was produced from a microfiche copy of the original document. The quality of the copy is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

PLEASE NOTE: Some pages may have indistinct print. Filmed as received.

Canadian Theses Division
Cataloguing Branch
National Library of Canada
Ottawa, Canada K1A 0N4

AVIS AUX USAGERS

LA THESE A ETE MICROFILMEE TELLE QUE NOUS L'AVONS RECUE

Cette copie a été faite à partir d'une microfiche du document original. La qualité de la copie dépend grandement de la qualité de la thèse soumise pour le microfimage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

NOTA BENE: La qualité d'impression de certaines pages peut laisser à désirer. Microfilmée telle que nous l'avons reçue.

Division des thèses canadiennes
Direction du catalogage
Bibliothèque nationale du Canada
Ottawa, Canada K1A 0N4

THE UNIVERSITY OF ALBERTA

ARE ATTITUDES TOWARD THE MENTALLY ILL CHANGING?
A RETURN TO THE BASELINE TOWNS

by

JOAN BROCKMAN ©

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF ARTS

DEPARTMENT OF SOCIOLOGY

EDMONTON ALBERTA
SPRING, 1976

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled ARE ATTITUDES TOWARD THE MENTALLY ILL CHANGING? A RETURN TO THE BASELINE TOWNS submitted by Joan Brockman in partial fulfilment for the degree of Master of Arts.

James C. Hackler
Supervisor

Sharon McIrvin Abu-Laban

Lewis H. Thomas

November 7, 1975

ABSTRACT

This thesis examines changing attitudinal social distance toward the ex-mental patient, correlates of these attitudes and the implications research methods and tactics have on research findings.

A review of the literature suggests that, in the late 40's and the 50's, public attitudes toward the mentally ill were negative. Although studies from the 1960's onwards are usually interpreted as reporting more positive attitudes, a significant group of researchers have questioned the nature and extent of reported changes in public attitudes. A detailed analysis of standard social distance items reported in various studies suggests that there is a trend toward more tolerant attitudes. However, given the variation in magnitude and direction of change one must conclude that the case for increasing public tolerance is by no means clear cut.

In order to look more closely at the extent to which public acceptance has changed, the Cummings' 1951 Closed Ranks study area was re-examined, using essentially the same research instruments and tactics.

The findings show no dramatic change in the public attitudes toward the ex-mental patient. However, there were some changes. Out of twelve social distance items there were statistically significant increases in five:

the acceptance of the ex-mental patient as tenant, roommate, a person to fall in love with, a person for your children to marry, and a willingness to marry a member of a family in which there was mental illness (only the last two were of a substantial magnitude). An overall view leads one to conclude that verbally expressed attitudinal social distance toward the ex-mental patient has changed somewhat in the direction of increasing public acceptance of the mentally ill; though the order of magnitude is less than what a conventional reading of the literature would suggest.

The often found negative relationship between age and attitudinal social distance toward the ex-mental patient was at first substantiated. However, a more detailed analysis showed that the three items pertaining to marriage were highly associated with age and when they were excluded from the index there was no longer a relationship between age and attitudinal social distance.

An additional analysis of attitudinal change over time, excluding the marriage items, did *not* substantiate our earlier couclusion that attitudes toward the ex-mental patient had improved in the last 23 years.

An analysis of the literature on attitudes toward the ex-mental patient suggests that researchers using the interview method are finding more "accepting" attitudes than those using the self-response instrument. There is a tendency for psychiatrists and mental health workers to report positive attitudes and for sociologists and psychologists to report negative attitudes. Hence, the former are more inclined to recognize "change" than the latter.

Acknowledgements

The study described in this Thesis was supported in part by funds from the Psychiatric Services Branch of the Saskatchewan Department of Health and from a research grant from Mental Health Saskatchewan and Associated Canadian Travellers. The author wishes to thank C. D'Arcy, J.A. Schmitz and S.D. Goldie from the Applied Research Unit, University Hospital in Saskatoon for their support and assistance.

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION 1

The Sociological Problem
Overview of Theory and Research
Purpose of the Study
Hypotheses
Research Procedures
A Problem of Definition
Plan of the Thesis

CHAPTER II. REVIEW OF THE LITERATURE 13

Research Before 1960
Research Since 1960
  The optimistic findings
  Some contrary findings
A Critical Analysis
Determinants of Attitudinal Social Distance
  Age
  Education
  Sex
  Familiarity
Conclusion

CHAPTER III. CLOSED RANKS: THE 1951 STUDY 40

The Educational Program
Data Collection
Data Presentation
Analysis of Data
Interpretation of Results

CHAPTER IV. PROBLEMS WITH A RE-STUDY 51

Measuring Social Distance
Distributing the Questionnaire
Problems with Data Presentation

CHAPTER V. OPENED RANKS: THE 1974 RE-STUDY 60

The Communities
Research Instruments
Research Procedures
Response Rates and Sample Characteristics

CHAPTER VI. DATA ANALYSIS 70

Attitudinal Social Distance, 1951-1974
   Blackfoot
   Education, age and social distance
   Deerville
Comparison of Blackfoot and Deerville, 1974
Another Measure of Social Distance
Determinants of Attitudinal Social Distance
   Constructing an index
   Age
   Education
   Age and education
   Sex
   Familiarity
A More Detailed Analysis

CHAPTER VII. THE IMPACT OF RESEARCH STRATEGY ON FINDINGS 92

Methodological Problems
   Method of gathering data
   Interviewer effect
   Standards for the interpretation of data
   Who is interpreting the data
A Framework for Understanding Survey Results
   Interview vs self-response questionnaire
   Researchers
   Interaction of professional background and method
Theoretical Issues
   Generalizations
   The idiographic factor
Blackfoot 1974 and Saltwater 1965
Recapitulation

APPENDIX A. 110

APPENDIX B. 111

APPENDIX C. 112

APPENDIX D. 113

TABLES 114

FIGURES 140

REFERENCES 147

LIST OF TABLES

Table	Description
2.1	Social acceptance of the ex-mental patient
3.1	Comparison of attitudinal social distance toward ex-mental patients in Blackfoot and Deerville, 1951
3.2	Relationship between education and attitudinal social distance toward the ex-mental patient in Blackfoot, 1951
3.3	Relationship between age and attitudinal social distance toward the ex-mental patient in Blackfoot, 1951
3.4	The percentage of positive responses to "core" social distance items in the experimental town before and after the educational program, 1951
6.1	Percentage of respondents answering in an accepting manner to social distance items concerning the ex-mental patient, Blackfoot 1951 and 1974
6.2	Comparison of attitudinal social distance toward the ex-mental patient in Blackfoot, 1951 and 1974
6.3	Relationship between education and attitudinal social distance toward the ex-mental patient, Blackfoot, 1951 and 1974
6.4	Relationship between age and attitudinal social distance toward the ex-mental patient, Blackfoot, 1951 and 1974
6.5	Comparison of attitudinal social distance toward the ex-mental patient in Deerville, 1951 and 1974
6.6	Percentage of respondents answering in an accepting manner to social distance items concerning the ex-mental patient, Deerville 1974 and Blackfoot 1974
6.7	Relationship between age and attitudes toward the ex-mental patient in Blackfoot and Deerville combined, 1974
6.8	Relationship between education and attitudes toward the ex-mental patient in Blackfoot and Deerville combined, 1974
6.9	Relationship between education and attitudinal social distance controlling for age, Blackfoot and

Deerville combined, 1974

6.10a Relationship between age and willingness to trust someone who had been mentally ill with financial matters, Blackfoot and Deerville, 1974

6.10b Relationship between age and willingness to marry a member of a family in which there was mental illness, Blackfoot and Deerville, 1974

6.11 The relationship between demographic variables and thirteen social distance items, Blackfoot and Deerville, 1974

7.1 Comparison of attitudinal social distance between poorly educated rural population and teachers items

7.2 The influence of research method on reported attitudes toward mental illness

7.3 The influence of professional background on reported attitudes toward mental illness

7.4 The relationship between professional background and reported findings while controlling research method

7.5 Percentage of respondents answering in an accepting manner towards the ex-mental patient, Saltwater 1965 and Blackfoot 1974

LIST OF FIGURES

Figure

2.1 Acceptance of the ex-mental patient as 'a person for the respondent's children to marry', in eighteen study areas, 1951-1973

2.2 Acceptance of the ex-mental patient as 'a person to fall in love with', in nine study areas, 1951-1970

2.3 Acceptance of the ex-mental patient as a roommate in twelve study areas, 1951-1973

2.4 Acceptance of the ex-mental patient as tenant in an apartment, in six study areas, 1951-1970

2.5 Acceptance of the ex-mental patient as workmate, in fifteen study areas, 1951-1973

2.6 Willingness to sell an adjoining lot to an ex-mental patient, in four study areas, 1951-1968

2.7 Willingness to sponsor an ex-mental patient in a club, in eight study areas, 1951-1970

CHAPTER I. INTRODUCTION

This thesis re-examines additudinal social distance toward the ex-mental patient by returning to the study area of an important baseline experiment carried out in Saskatchewan in 1951. The impact of research methods on survey results is discussed and a framework is presented to aid in the understanding of divergent survey findings which have occurred in this area of research in the last 15 years.

The Sociological Problem

Historically some societies have displayed compassion and tolerance toward their "misfits", caring for them and allowing them to function as best they could in the community, while other societies have rejected them - mutilating, executing or confining them.

The movement toward incarceration of the mentally ill, in North America, began in the early 19th century. In Canada, before 1850 many non-criminal "lunatics" were kept in jails because their number exceeded the facilities available in asylums. The building of new asylums and the transfer of "lunatics" from common jails were considered humanitarian moves.

Today, the treatment of the mentally ill is part of a larger movement. Rothman describes what has happened.

> Over the course of the past several decades, without clear theoretical justification or even a high degree of self-consciousness, we have been completing a revolution in the treatment of the insane, the criminal, the orphaned, the delinquent, and the poor. Whereas once we relied almost exclusively upon incarceration to treat or punish these classes of people, we now frame and administer many programs that maintain them within the community or at least remove them as quickly as possible from institutions. Policy makers in each of these areas interpret their own measures as specific responses to internal developments - an advance in drug therapy or a dissatisfaction with prevailing penitentary conditions - not as part of a general anti-institutional movement. But such a movement exists. . . (1972:3).

The attitude of the public toward the mentally ill is a subject of growing concern and research effort. Rabkin (1972) notes in her review article that there has emerged a sizable body of research concerned with public attitudes toward the mentally ill and the extent to which such attitudes are amenable to modification and change.

In the late 1940's and the early 1950's there emerged an initial concern with the question of public attitudes toward the mentally ill. While being of some theoretical interest, sociologically, the concern also stemmed from the practical implications of the proposed changes in the modality of treatment of psychiatric patients. There had, at that time, been a growing concern with the "institutionalization syndrome" arising from prolonged hospitalization. It was also felt that the attitudes of the public had a demonstrable effect on the degree of adjustment achieved by a patient released from psychiatric hospitalization and his success in avoiding rehospitalization. The difficulties faced by the ex-patient upon return to the community have often been compared to the hardships of the ex-convict; housing, jobs, friends, and community acceptance are problems common to both.

The growth of community psychiatry, the most recent development in the delivery of psychiatric care in Canada and the United States, has resulted in an increase and expansion of outpatient clinics, foster homes, boarding homes, half-way houses, residential centers and approved homes.[1] The success of this movement will depend to a significant extent on whether or not the "ranks" are open, i.e. how much social distance does the public place between itself and the ex-mental patient? To some extent a measure of social distance is also a measure of the stigma attached to the label "mentally ill".[2]

Overview of Theory and Research

Studies in the late 40's and early 50's reported highly "negative" attitudes toward the mentally ill. Of these studies, one conducted by Elaine and John Cumming in Saskatchewan, in 1951, has frequently been used as a baseline on which to gauge changes in attitudes toward mental illness.

Research since 1960 has resulted in divergent findings. One dimension of the debate has centered on the question, "how much social distance does the public place between themselves and the former mental patient?" On the one hand, some researchers have reported that there is no longer evidence of extreme rejection of the mentally ill. On the other hand, a dissenting faction claims that there is still considerable stigma attached to the label "mentally ill" and that the public reaction to a person so labeled is one of rejection.

Methodological and theoretical problems raise questions about the findings reported in the literature. There are important differences in the execution (i.e. interview vs. self-response questionnaire) of the original baseline study and subsequent studies that could account for some of the findings. One could also question the assumed national and international homogeneity of public attitudes that has occurred in many studies.

Purpose of the Study

This thesis reports on a re-study of public attitudes toward the ex-mental patient, in terms of social distance, utilizing essentially the same research instrument used in the original Closed Ranks study. This re-study, which was conducted in the experimental and control towns (Blackfoot and Deerville respectively) used in the original Cummings' study, had the following objectives: (1) To establish a framework, for understanding past discrepancies in findings regarding attitudes toward mental illness. (2) To determine to what extent attitudes toward the ex-mental patient in Blackfoot and Deerville had changed, if indeed they had. (3) To examine the determinants of public attitudes toward the former mental patient. Variables such as age, sex, education and familiarity with mental illness will be examined.

Hypotheses

The following hypotheses were proposed.

Hypothesis one. Attitudes toward the mentally ill in Blackfoot and Deerville will have become more accepting.

Hypothesis two. Positive attitude change in Blackfoot and Deerville, as indicated by the self-response questionnaire, will be less than the changes reported in other communities where the interview technique was used.

Hypothesis three. There will be a tendency for psychiatrists and Mental Health Workers to report positive attitudes toward the mentally ill and for sociologists and psychologists to report negative attitudes.

Hypothesis four. Age is inversely related to favorable attitudes toward the ex-mental patient.

Hypothesis five. Education is directly related to favorable attitudes toward the ex-mental patient. The influence of education should be independent of age.

Hypothesis six. Sex will not be related to attitudinal social distance.

Hypothesis seven. The more familiar the respondents are with people who have been mentally ill the more accepting their attitudes will be.

Research Procedures

Twenty percent random samples were drawn from the voters' lists, compiled for the July 1974 federal election, in the Cummings' experimental town of Blackfoot and their control town of Deerville.

The questionnaires were mailed out with a letter of introduction from the research director, a stamped self addressed return envelope and a stamped self addressed "Completion Notification Card", which was to be returned separately indicating that the respondent had completed and mailed in the questionnaire.

Two waves of replacement questionnaire packages were mailed out to non-respondents.

A Problem of Definition

The term "ex-mental patient" is a somewhat "disembodied" label (Kirk, 1974). What behavior does the public define as "mentally ill"?

Various studies have used Star's (1952) six vignettes to determine the behaviors which the public defines as manifestions of mental illness. In reviewing the literature of the early 1950's it appears that the term "mental illness", as used by the public, covers a much narrower range of abnormal behavior than that used by the Mental Health profession. A single operational definition used by the public might be 'the mentally ill are those who enter a psychiatric hospital' (Cumming and Cumming, 1957; Nunnally, 1961; Johannsen, 1969; and Scott, 1973). The Cummings offered the following definition:

> Mental illness, it seems, is a condition which afflicts people who must go to a mental institution, but up until they go almost anything they do is fairly normal (1957:102).[3]

In 1957 Star stated that the public's reaction to psychiatry was that "anyone who needs psychiatric treatment should see a psychiatrist, but that practically no one ever needs psychiatric treatment" (1957:3).

Since 1950 there have been attempts by Mental Health Workers to "educate" the public; that is, to make them see an ever expanding amount of deviant behavior as mental illness in need of psychiatric treatment. The question arises, is there an increasing tendency, on the part of the public, to recognize a wider variety of "deviant behavior" or "psychological disturbances" as mental illness?[4] Sarbin and Mancuso (1970) would suggest, the man on the street is not ready to use the label "mentally ill" to categorize behavior that a professional would diagnose as mental illness. In addition, they see stigmatization and rejection as an unintended consequence of labeling deviant behavior as mental illness. In contrast, Crocetti et al. feel that the literature has documented the increasing capacity of the public to recognize mental illness, and that along with this medical framework is the assumption of sympathy and faith that "the enlistment of prestigious scientific methods will return the individual to health" (1974:162).[5]

Plan of the Thesis

Chapter II presents a detailed review of the literature. The original baseline study, Closed Ranks, which was carried out by Elaine and John Cumming in Saskatchewan, 1951, will be the subject matter of Chapter III. Chapter IV discusses some of the problems encountered in an attempt to re-study the Cummings' baseline towns. Opened Ranks, the resurvey of the towns studied in Closed Ranks, is the topic for Chapter V. Chapter VI presents the data analysis and Chapter VII discusses the influence research methods and tactics have on research findings. A framework is provided to aid in the understanding of divergent survey results and thus cast light on some of the controversy surrounding the extent of change in public attitudes toward mental illness.

Footnotes

1. A study of psychiatric morbidity patterns for the province of Saskatchewan, 1932 to 1970, indicates that while there has been a significant change from the "traditional" system to community psychiatry there has not been a decrease in institutional rates. In fact admissions and discharges for psychiatric hospitalization as well as the likelihood of hospitalization and treatment for psychiatric illness has increased. But there has been a decrease in the length of hospital stay and in the number of people resident in institutions. The increase in the likelihood of someone being treated for psychiatric illness has resulted in a greater possibility of someone becoming an ex-mental patient (D'Arcy, 1974).

2. The term "mentally ill" is a somewhat "disembodied" label (Kirk, 1974:115). While many studies have used this label others have investigated the characteristics of the mentally ill which make them more susceptible to rejection. Rabkin summarized the characteristics needed to maximize public aversion: "male, lower class, probably black, violent, hearing voices, showing bizarre behavior and lacking social ties with the community" (1974:20). Nunnally states that predictability is important; "because unpredictable behavior is frightening and

disruptive. . . much societal machinery is devoted to making the behavior of individuals predictable to others" (1961:46). In light of this discussion one could ask if there is any warrant for a study of attitudes toward a somewhat "disembodied" label. Kirk seems to think so. He states that, "persons are often known by their labels and little else. . . and the label provides the only bases on which people make inferences about others" (1974:115).

3. The Cummings give the example of a paranoid woman who was convinced she had been under the influence of sex rays for some 15 years. She held down a normal job but confided in her sister with whom she lived. After an unexpected separation from her sister she confided in a friend who placed her under psychiatric examination. After a short stay in the hospital her sister was reluctant to have here back saying, "How do I know what she might do?"

4. The interchangeability of the terms "deviant behavior" and "psychological disturbances" reflect the debate in the literature between some Mental Health Workers who consider particular symptoms or behavior to be an illness requiring psychiatric help and those who would view them as a form of social deviance.

5. The question of public recognition of psychiatric

symptoms was re-examined by D'Arcy and Brockman (1975) by returning to the Cummings' Closed Ranks study area. There was no evidence to support post 1960 findings that public recognition of psychiatric symptoms had increased dramatically. Blackfoot 1974 results were more like the original Cummings' 1951 study than any other study. There were, however, a few changes. There was a significant decrease (11 percentage points) in the public recognition of the anxiety neurotic and a slight increase (7 percentage points) in the recognition of the juvenile character disorder.

CHAPTER II. A REVIEW OF THE LITERATURE

It is usual for researchers to note that studies in the late 40's and the 50's reported "negative" attitudes toward the mentally ill. Although studies from the 1960's onwards are usually interpreted as reporting more "positive" attitudes, a significant group of researchers have questioned the nature and extent of reported change in public attitudes.[1]

Research Before 1960

In 1941, Allen interviewed a sample of the leadership group of Dallas, Texas in order to throw light upon "the present stage of development of the study and practice of mental hygiene and upon further needs" (1943:248). He stated that "community education" was the most common suggestion received from the sample. In their book, Contemporary Attitudes Toward Mental Illness, Crocetti *et al.* (1974) write, "the first application of the concept of social distance to attitudes toward the mentally ill was in 1943 when it was found that fear, stigmatization, and rejection characterized public feeling about the mentally ill (Allen, 1943)" (Crocetti *et al.*, 1974:5). Allen did not use social distance items nor did he conclude anything similar to what Crocetti *et al.* write.

In 1947, Ramsey and Seipp (1948), using a stratified sample of adults in Trenton, New Jersey, reported data on the public's opinions and information concerning the etiology and treatment of mental illness. Ramsey and Seipp's results were very limited, as Rabkin points out, because of their restricted use of etiological concepts (e.g. "Do you believe that insanity is God's punishment for some sin or wrong doing?" or "Do you or do you not believe that people who are around those who are insane tend to become odd or strange themselves?") together with the "brevity of the interviews and absence of statistical analysis" (1974:11). Ramsey and Seipp's research effort had been stimulated by the United States Public Health Services desire to educate the public through "elimination of misconceptions and undesirable attitudes". The researchers concern was that, "very little research had been done regarding the opinions and attitudes actually held by the public" (1948:428). Their results were presented descriptively, in percentage form and their conclusions were limited to their findings. Having no similar earlier data to compare their findings with, they made no suggestions to the effect that public attitudes were "moving" anywhere; as Crocetti _et al._ (1971) stated.

> As early as 1948 Ramsey and Siepp noticed that the public was moving toward a humanitarian and scientific point of view toward mental illness (Crocetti _et al._, 1971:41).

Crocetti _et al._ (1971) also suggest that Woodward

(1951) and Roper (1950), conducting a public opinion poll in Louisville, Kentucky, reached conclusions similar to that of Ramsey and Seipp; that is, attitudes were "moving toward a humanitarian and scientific point of view". Woodward states,

> people are definitely moving toward a humanitarian and scientific point of view toward mental illness. . . The old ideas that the mentally ill were bad and dangerous, and hence to be punished or were ludicrous and silly, and hence to be laughed at seem to be to a considerable extent superseded by the feeling that mental illness is a sickness that should evoke sympathetic understanding (1951:444).

Woodward presents no data on those "old ideas". Had a public opinion poll been carried out in those "old days" would respondents have said, "yes, the mentally ill should be punished and laughed at"?

The results also appear to point to some confusion on the part of the public and it is obvious that social desirability may have been operating. Woodward writes,

> When asked the open question on what ought to be done about the fifteen-year-old truant and automobile stealer the most frequent responses are of the repressive type (punish him, send him to reform school). But the minute the boy's club is suggested to them as one of six possible courses of action it commands clear majority support. The reformatory and the "old-fashioned whipping" retreat almost to the bottom of the list, behind juvenile probation and referral to a psychiatrist (1951:448).

In 1950, in the United States, Star (1952) conducted a nationwide survey of public attitudes toward the mentally ill and concluded that the frequent reaction of the public was one of "fear, distrust, suspicion, and apprehension deriving primarily from the assumption that the person could not really be cured" (1952:23). Star also stated that the beliefs and superstitions surrounding these attitudes were a "real hindrance to the readjustment of recovered patients in normal society" (1952:25).

In 1951, Elaine and John Cumming, (1957) introducing the first social distance scale to study attitudes toward the mentally ill, concluded that the public attitudes were not only rejecting but also unremitting (i.e. resistant to change). This conclusion was reached on the basis of a social distance scale administered to a control town and an experimental town before and after a six month educational program.

Star's American study and the Cummings' Canadian study, each concluding that the public was socially and physically isolating the mentally ill, provided confirmation for each other. Because of their relatively similar findings they have assumed national and international importance as a baseline for subsequent studies of attitudes toward mental illness.

Over a six year period (1954-59) Nunnally carried out an extensive survey on attitudes and information held by the public and mental health workers in central Illinois. He stated that the public was not grossly misinformed but uninformed. Using the semantic differential technique Nunnally concluded that there was a strong "negative halo" associated with the label mentally ill and that "the average man generalizes to the point of considering the mentally ill as dirty, unintelligent, insincere, and worthless" (1961:233).

In 1956, Whatley carried out a study in Louisiana using eight social distance items and concluded that the recovering mental patients were returning to "socially unhealthy environments. . . and risking a certain amount of social isolation through curtailed interaction opportunities in primary groups" (1959:319). He suggests that studies reporting a liberalizing trend in attitudes toward mental illness and other social areas should give serious attention to whether or not indicated change has occured at the primary-group level as opposed to remote, impersonal situations.

Crocetti _et al._ (1971) interpret Gurin _et al._'s study (1960) as another indication that attitudes toward mental illness had improved. Their one finding that may relate to attitudinal social distance toward the mentally ill is that, of those who felt they could have used some help but didn't go for help, shame and stigma ranked as the third most important reason (Gurin _et al._, 1960:350).

Crocetti _et al._ (1971) also state that Ridenour (1961) had reported much improvement in individual attitudes toward the mentally ill by the late 1950's (1974:9). Beginning in the early 1900's when fees were charged to tease the "crazy" people and chains and cages were common, Ridenour (1961) traced the mental health movement up until the late 1950's. She states that in 1958 an opinion poll revealed that Americans were more willing to pay taxes for the care of the mentally ill than any other major public service. She states, "what a change since 1908!" (1961:132). Ridenour also points to the growth in volunteer movements, coverage of mental illness in health insurance plans, general feelings of less shame, etc. as indicative of "much healthier attitudes" (1961:139). Although Ridenour does state that attitudes were more positive by the late 1950's, Crocetti et al.'s statement that she had "found much improvement in individual attitudes toward mental illness" (1971:1122) is misleading.

The final report by the Joint Commission on Mental Health and Illness stated that one fundamental difference between mental and physical illness is that mental illness "tends to disturb and repel others rather than evoke their sympathy and desire to help" (1961:xviii). The report also stated that the problem of public stigmatization and rejection of the mentally ill interfered with the treatment process and that attempts should be made to overcome this "pervasive defeatism".

In her comprehensive review of the literature Rabkin states that, "by 1960 it was unambigiously established that mental patients were dimly regarded in the public view" (1974:12).

Research since 1960

Research since 1960 has resulted in divergent findings, or at least divergent interpretations of findings. As Crocetti et al. note,

> there are those who see society as rejecting the mentally ill, displaying hostility toward them and closing its ranks against them; and those who believe that society is generally accepting of the mentally ill, is compassionate toward them, and is willing to accept them into its ranks (1974:xii)

Crocetti et al. and Rabkin (1974) also identify another tension between mental health workers; those who consider mental illness an illness and those who subscribe to the social deviance model. There appears to be a basic difference in "underlying ideologies" (Rabkin) or "premises and perspectives" (Crocetti et al.). Crocetti et al. feel that the debate has "degenerated into passionate polemics" (1974:xiii).

A review of both positive and negative reports since 1960 is necessary if one is to expose the essence of these incompatible conclusions.

The "optimistic" findings. In 1960 Lemkau and Crocetti (the founding and most vocal optimists) carried out a study in a lower socioeconomic section of Baltimore in order to predict the public's acceptance of a home care plan for psychiatric patients. They arrived at what they referred to as "startling results". Their data did not substantiate the Cummings' hypothesis that the general public isolates and rejects the mentally ill. For evidence Lemkau and Crocetti cite percentages. They found that 50% of their sample said that they "could imagine themselves falling in love with someone who had been mentally ill"; 50% said they "would be willing to room with someone who had been a patient in a mental hospital"; 81% said they wouldn't hesitate to work with someone who had been mentally ill"; 62% disagreed with the statement "almost all persons who have a mental illness are dangerous"; 85% agreed that "people who have some kinds of mental illness can be taken care of at home" and three fifths agreed with the statement that "people who have been in a state mental hospital are no more likely to commit crimes than people who have never been in a state mental hospital" (1962:698). The authors also claimed that their results varied "on a wide range of points from many previous studies using identical or similar questions and comparable methodology" (1962:698).

Meyer (1964) replicated Lemkau and Crocetti's study in Easton, Maryland and came up with similar results - more tolerant attitudes. The sampled population was described as "rational and humane in its verbally expressed attitudes toward mental illness" (1964:772). Crocetti _et al._ note some of the more favorable results of Meyer's study, such as 78% did not feel that all mental patients were dangerous; 88% did not think that locked doors were the best way to handle mental hospital patients; 94% knew of the existence of different forms of mental illness; and 89% were in favor of home care for patients where medically appropriate (1974:12). However, when one looks at Meyer's data one can also see that only (?) 45% disagreed with the statement "we should strongly discourage our children from marrying anyone who has been mentally ill"; and only 55% would be "willing to room with someone who had been mentally ill".

In 1962, the Kentucky Mental Health Planning Commission interviewed a sample stratified by rural and urban residences in order to prepare for community health programs. Crocetti _et al._ state that the results were similar to those in Baltimore, and again they select certain figures; 81% were willing to work with a former mental hospital patient; 54% to room with him; and 68% to work in a mental hospital (1972:2). On examining the Commission's other results we find that only 25% disagreed with the statement "we should strongly discourage our children from marrying anyone who has been mentally ill"; and only 35% could imagine falling in love with someone who had been mentally ill.

Dohrenwend and Chin Shong, in summarizing their findings from two studies, one of Manhattan, New York leaders in 1960-61 and the other of Manhattan, New York residents in 1963-64, concluded that "the leaders expressed less social distance from ex-mental patients than the cross-section of respondents at all educational levels" (1967:430). The data indicates that the leaders had more accepting attitudes than the 1951 Blackfoot population but some of the attitudes of the public were more rejecting (see Table 2.1).

In 1964, Tershakovec published a paper stating that attitudinal research alone gave too "piecemeal" a picture of public attitudes. Upon examining changes in the judiciary procedures used for psychiatric hospitalization (i.e. decline in use of committment) he concluded that public attitudes toward mental illness were becoming more favorable.

A study carried out by Rootman and Lafave (1969), in a small Saskatchewan town (similar in some aspects to the Cummings' experimental town of Blackfoot) led the authors to conclude that the public was placing less social distance between themselves and the mentally ill. They cautioned the reader, on the basis of one of their other studies in which a more "enlightened" community was actually less accepting of the mentally ill than a less "enlightened" town, that the increased verbal acceptance of the mentally ill "may not be tantamount to increased tolerance toward the mentally ill" (1969:256).

Edgerton and Bentz, upon reporting their results of a rural North Carolina and Virginia study, concluded that their sample expressed less desire for social distance between themselves and the mentally ill in comparison to the classic Blackfoot study (1969:473).

Similarly, in 1968 Ring and Schein carried out the Cobbs Creek survey, interviewing upwardly mobile lower-middle income black adults in Philadelphia, and found that respondents expressed a willingness to associate with ex-mental patients as fellow workers, club members, and neighbors. However, some reluctance was reported in the acceptance of an ex-patient as a roomer and to have a member of the respondents' family marry an ex-patient (1970:716).

Concerned with public policies that assumed psychiatric patients faced "community stigma and rejection", Crocetti _et al._ carried out another study in 1970 on a population of United Auto Workers members and their wives in the city of Baltimore. They concluded that there was no evidence of extreme rejection of the mentally ill. They write, "we must move away from assumptions based on studies of two decades ago. The time may have come to write a belated epitaph to the long-vanished 'closed ranks'" (Crocetti _et al._, 1971:1126).

Some contrary findings. Such a review of the literature would suggest that attitudes have indeed changed. But have they? Since 1960 there has been a dissenting faction that claims there is still considerable stigma attached to the label "mentally ill" and that the public reaction to a person so labeled is one of rejection.

At the same time Lemkau and Crocetti were doing their study in Baltimore, Phillips did a study in Branford, Connecticut interviewing 300 married women. He found increasing rejection of an individual who was described as having seen a clergyman, physician, psychiatrist or having been in a mental hospital (1963).[2] On the basis of comparing rejection of a "normal" individual who had and had not been hospitalized for mental illness he concluded that seeking psychiatric help had a stigmatizing effect and that there still existed "relatively strong negative attitudes toward ex-mental patients" (1966:762).

Floyd and Roman (1971) replicated Phillips' Branford study in Milledgeville, Georgia and came up with a similar overall pattern of rejection.

In 1960, Lamy surveyed an introductory psychology class and concluded that ex-mental patients would suffer a "depreciation of social esteem in a wide range of social roles" (1966:454). He notes that a prison record is preferred to time in a mental hospital.

In 1962, Badgley _et al._ (1966) studied the attitudes of 220 Saskatchewan Wheat Pool members toward the ex-mental patient and concluded that there was no major shift in attitudinal social distance through time.

Elinson _et al._ came to ambiguous conclusions concerning their New York study findings. They concluded that there were "chinks in the traditional public armor of rejection of the mentally ill" but also that mental illness tends to repel people (1967:xiv).

However, Crocetti _et al._ interprete these findings as similar to their Baltimore survey. They note that Perkins, in the preface, writes that,

> The public does not globally reject the mentally ill. On the contrary, the public does have hope for a favorable outcome to treatment of the patient, and accepts the proposition that this should be as near home as possible (Perkins _et al._, 1967 in Crocetti _et al._, 1972:2).

Rabkin acknowledges Elinson _et al.'s_ ambiguity and notes that though over three-quarters of the respondents saw mental illness as repelling to most people, only 16% admitted to being repelled by mental illness themselves. She concluded that while candid rejection of the mentally ill seems to be less socially acceptable today, mental patients are still regarded as "undesirable companions - unreliable, immature, not really trustworthy, with a more or less chronic loss of status" (1974:17).

Pratt _et al._ studied clinical, social, economic, and political attitudes of people in a "town-community" toward a "hospital-community" and concluded that the townspeople still perceived the mentally ill in terms of negative sterotypes which were perhaps justified twenty years ago but are now "outdated and unwarranted" (1970:217).

Crumption _et al._ studied junior college students, using a semantic differential, and concluded that their image of the mental patient was "unflattering". Some of the common adjectives used to describe the mental patient were: excitable, foolish, unsuccessful, slow, untimely, passive, cruel, weak, and ugly (1967:47).

MacLean reported that mental patients were viewed as potentially unpredicatable and violent, and possibly contagious and unacceptable in intimate roles (1969:50).

Using a 9-point social distance scale with the extreme responses being "would marry" and "would put to death", Tringo (1970) established a hierarchy of preference toward disabled groups. The four groups that were consistently ranked lowest were ex-convict, mental retardation, alcoholism and mental illness.

In a paper which summarizes much of their work Farnia _et al._ (1974) write that the consequences of being labeled mentally ill are "uniformly negative". The mentally ill are

> perceived as displaying behavioral deficiencies which, objectively, do not exist. They are treated differently and, apparently, less favorably than people not stigmatized by a psychiatric history. For instance, when a shock must be used to inform them that they have made an error, they are likely to be given longer shock. Further, employment interviewers discourge them about the prospects of finding a job and are less friendly toward them. Ex-mental patients are aware of these public attitudes and dispositions and this causes additional difficulties. When they think their history is known, they have been shown to feel less appreciated and perform a task more poorly. They also appear more tense, anxious and poorly adjusted to a neutral observer.
>
> These reports suggest that successful reentry into the community is not an easy matter for anyone who has been in a mental hospital. The process would appear to be particularly difficult for them, since presumably they have long experienced special difficulties in coping with the world and these difficulties may be expected to continue after discharge (1974:108).

A Critical Analysis

Is there an increasing tendency, on the part of the public, to accept the ex-mental patient into its ranks or not? In spite of the controversy, the predominant theme in the literature since 1960 suggests that attitudes have become more "positive". Bentz and Edgerton state that,

> it seems reasonable to credit the efforts of the National Association for Mental Health, and its state and local affiliates, and other agencies concerned with mental ~~health~~ problems, for their work in educating the public. The advent of the mass media, especially television. . . has also undoubtedly been an

important factor (1970:468).

One of the unique aspects of a large number of these studies of public attitudes toward the mentally ill has been the use in total or in part of standard social distance items. One method of assessing to what extent social distance toward the mentally ill has changed would be to analyze the data reported in these studies. Table 2.1 provides a detailed analysis of results obtained in various studies which utilized similar social distance questions.

Based on the predominant theme in the literature one could introduce the following substantive hypothesis: attitudes toward the mentally ill have become more "accepting" since 1951. Using Blackfoot as a baseline and entertaining a null hypothesis of no difference, Table 2.1 reports on the significances of attitudinal changes. The majority of changes suggest that there is an increasing acceptance of the ex-mental patient in various social roles. However, there are some studies in which no change or more rejecting attitudes are reported.

Table 2.1 here

In response to accepting the ex-mental patient as "a person for respondent's children to marry," twelve out of seventeen studies reported statistically significant and substantial increases in acceptance.[3] Figure 2.1 illustrates that increases ranged from ten (studies 7, 11 and 19) to 36 percentage points (Study 18). The average increase over the eleven studies was 17 percentage points.

Figure 2.1 here

Five studies reported slight decreases in acceptance of the ex-mental patient in terms of children marrying while study 4 reported a decrease of ten percentage points.

Five out of eight studies reported a statistically significant and substantial increase in the acceptance of the ex-mental patient as 'a person to fall in love with'. Figure 2.2 illustrates that studies 3, 6, 12, 14, and 17 showed increases of 19, 12, 36, 13 and 32 percentage points respectively while study 8 showed an increase of only 4 percentage points. Studies 9 and 15 showed decreases in acceptance of 6 and 7 percentage points respectively.

Figure 2.2 here

As a roommate, nine out of eleven studies reported a statistically significant increase in acceptance of the ex-mental patient (eight were substantial). Studies 6, 7, 8, 9, 12, 14, 17, and 19 reported substantial increases of 11, 20, 10, 15, 34, 14, 35, and 15 percentage points respectively while study 3 reported a slight increase (7 percentage points). Studies 10 and 15 reported decreases of 21 and 8 percentage points respectively (see Figure

2.3).

Figure 2.3 here

In response to "renting an apartment" to the ex-mental patient three out of five studies reported a statistically significant increase (two of a substantial amount) and one reported a substantial increase in rejection of the ex-mental patient. Figure 2.4 illustrates that studies 5, 14, and 18 reported increases of 26, 7, and 19 percentage points and studies 10 and 16 reported decreases of 6 and 13 percentage points.

Figure 2.4 here

As a workmate, thirteen out of fourteen studies reported an increase in acceptance, ten of which were statistically significant. Increases ranged from two to twenty-five percentage points with an average increase of 13 percentage points. Study 15 reported a decrease of nine percentage points (see Figure 2.5).

Figure 2.5 here

Figure 2.6 illustrates that all three studies indicate a negative change in response to "selling an adjoining lot" to the ex-mental patient; one substantial (study 15 showed 21 percentage point decrease) and the other two slight decreases (studies 9 and 14 showed five and one percentage point decreases respectively).

Figure 2.6 here

Four out of seven studies reported a statistically significant increase in the acceptance of the ex-mental patient as "one to sponsor in a club" (one was substantial), while three studies reported a substantial increase in rejection of the ex-mental patient (see Figure 2.7).

Figure 2.7 here

It would appear, despite the lack of uniformity in the direction and magnitude of change, that there is a common trend toward more tolerant attitudes; however, one cannot ignore the wide variation in the degree of change reported. For example, on the social distance item "a person for your children to marry", of the 17 studies, 12 reported a significant and substantial "positive" increase; but the percentage change ranged from 10 to 36 points, similarly the positive percentage changes reported for the workmate item ranged from 10 to 25 and for the roommate item from 10 to 34.

Given the variation in magnitude and direction of change reported in the literature one must conclude that the case for increasing public tolerance is by no means clear cut. Besides the debate in the literature and the analysis of findings reported in Table 2.1 and Figures 2.1 to 2.7 there are some methodological and theoretical problems that force one to be critical of accepting any overall trend. These issues will be addressed in Chapter

VII.

Determinants of Attitudinal Social Distance

Characteristics of respondents that influence the degree of public acceptance of the mentally ill have been of some interest to those involved in research concerned with such attitudes. A review of the literature suggests that four factors, age, sex, education and familarity, have been analyzed with respect to how they influence or correlate with attitudes toward the mentally ill.

Age. There is a consensus in the literature that younger people tend to have more enlightened and more humanitarian attitudes toward the mentally ill.

Woodward (1951) found that younger people were less likely than older people to believe that "most mental illness is inherited", and more likely to believe that most hospitals for the mentally ill don't treat their patients very badly, there were not enough doctors and hospitals for the care of the mentally ill, a hospital rather than a jail was the place for a sex criminal, etc. Needless to say some of these questions are based more on preference than on fact, nevertheless, the younger people were more "enlightened" - that is, they more readily conformed to the notions popularized by Mental Health Workers.

Middleton (1953), using a prejudiced test, found that the younger better educated hospital employees were less prejudice than the older employees.

Upon studying the attitudes of relatives of former hospitalized patients, Freeman (1961) demonstrated that age was related to attitudes even when education was controlled.

Nunnally (1961), using a semantic differential instrument found that younger respondents had slightly less derogatory attitudes but their attitudes were still rejecting.

Cohen and Struening (1962), using the OMI (Opinions About Mental Illness) questionnaire on hospital staff found that age was not related to the "Benevolence", "Mental Hygiene Ideology", or the "Interpersonal Etiology" factors; but, there was a slight relationship between being older and "Authoritarianism" and an even weaker relationship between age and "Social Restrictiveness".

Cumming and Cumming (1957), Whatley (1959), Crocetti and Lemkau (1963), Phillips (1964), Dohrenwend and Chin Shong (1967), Decision Making Information Canada (1974), and Crocetti et al. (1974), all using Bogardus type social distance items, concluded that the younger people were less rejecting of the mentally ill than the older people.

Using the Custodial Mental Illness Ideology Scale (CMI), Bates (1968) and Clark and Binks (1966) concluded that younger people have a more "humanistic" orientation while older people have a more "custodial" orientation. Individuals with a humanistic orientation conceived of the hospital as a therapeutic community while individuals with a custodial orientation were concerned with the control and safe-keeping of the mentally ill (Bates, 1968:250).

Maclean (1969) stated that people over 50 years of age were "more inclined to view the mentally ill with suspicion and alarm". Pratt et al. (1960) also found that the younger generation had more positive attitudes.

There has been little speculation as to why this relationship exists. Bates (1968) suggests it is perhaps a product of short life experience and questions whether this more humanistic attitude will be maintained "when today's 25 year old is 50, filling a post in legislature or a policy making position".

Education. Education also appears to be a major factor that influences attitudes. The better educated person is more humanitarian and "enlightened", less prejudice and less likely to reject the mentally ill (Ramsey and Seipp, 1948; Woodward, 1959; Middleton, 1953;

Cumming and Cumming, 1957; Whatley, 1959; Phillips, 1966; Clark and Binks, 1966; Dohrenwend and Chin Shong, 1967; Maclean, 1969; Laine and Lehtinen, 1973; and Decision Making Information Canada, 1974). More specifically the Cummings found that the more positive attitudes were accounted for by the difference between the "grade school only" and the more educated. They write, "apparently the decision to go to high school is critically related to attitudes toward mental illness in this population" (1957:74).

Nunnally found that more educated people held slightly less derogatory attitudes but all respondents tended to regard the mentally ill as "relatively dangerous, dirty, unpredicatable and worthless" (1961:51).

Although age and education are characteristically correlated there is some evidence that they influence attitudes independently (Clark and Binks, 1966; and Freeman, 1961). Freeman (1961) suggests that other socialization agents besides the formal educational system have influenced attitudes toward mental illness.

Sex. Sex appears to have little effect on atttitudes toward the mentally ill (Whatley, 1959; Phillips, 1963; Lawton, 1964; and Bord, 1971). Laine and Lehtinen (1973) found that Finnish men had more positive attitudes than Finnish women but this relationship was significant in the industrial and not the agricultural community.

Decision Making Information Canada (1974) found that males were slightly more prone to accept the mentally ill, however, Tringo (1970) found that females placed less social distance between themselves and disability groups.

Familiarity. There is some evidence that personal acquaintance with mentally ill people reduces attitudinal distance (Altrocchi and Eisdorfer, 1961; Freeman, 1961; and Phillips, 1963).

Swingle (1965) found that relatives were more rejecting of patients than non-related visitors. Chin Shong (1968) found that a close tie with the mentally ill, not acquaintance with a mentally ill patient, reduced social distance. However, there was more acceptance of a close friend than a family member who was mentally ill.

Rabkin (1974:23) cites the following studies reporting remarkable attitudinal change through actual contact with mental patients: Canter and Shoemaker, 1960; Chinsky and Rappaport, 1970; Gelfand and Ullman, 1961; Holtzberg and Gerwirtz, 1963; Johannsen, Redel, and Engel 1964; Kolmer and Kern, 1968; Kulik, Martin, and Scheibe, 1969; Lewis and Cleveland, 1966; Ralph, 1968; and Smith, 1969. However, she notes that these studies have generally used college students in volunteer programs and nursing students and that it seems "unlikely that they could have failed to receive the message. . . that they were supposed to adopt more humanistic views toward mental patients" (Rabkin, 1974:23).

In this vein, Homes (1968) investigated the effect of exposure to psychiatric patients on subjects who were not as motivated to change their attitudes. He concluded that exposure had no consistent effect on attitudes or behavior.

Whatley (1959) and Floyd and Roman (1971) found no relationship between acceptance of the mentally ill and familiarity with them. However, the majority of studies point to the existence of a relationship between familiarity and attitudes.

Conclusion

A review of the literature exposes the polemics surrounding the interpretation of data. That is, who interpretes the data and what results they choose to cite can determine the overall evaluation of study results. The following question arises: have researchers reporting different findings been dealing with different data or just different interpretations of data? Differences in the execution and the interpretation of the original Blackfoot study and later studies (discussed in Chapter

VII) also leads one to question whether or not reported survey results are artifacts.

A restudy of the Cummings' original baseline study, (reported in Chapter V) using essentially the same research instruments and tactics, offers the unique opportunity to look more closely at the question of changing public attitudes toward the ex-mental patient.

Footnotes

1. Confusion over the attitudes actually held by the public toward ex-mental patients is aggravated by misleading summaries, presented by some authors, of other researchers' findings. Crocetti and his associates have been guilty of misrepresentation quite often and, as illustrations, are cited frequently in my review of the literature.

2. Later, in a smaller pilot project Phillips demonstrated that those individuals identifying an individual as mentally ill were more rejecting than those not making such an identification (1967:265).

3. A change of ten or more percentages points is considered substantial (the cutting point was established arbitrarily).

CHAPTER III. CLOSED RANKS: THE 1951 STUDY

A study of particular interest, which has since been used as a baseline for the study of attitudes toward mental illness, was the study conducted by Elaine and John Cumming in 1951, in Saskatchewan. In their book, Closed Ranks (1957), the Cummings describe their attempt to change public attitudes toward mental illness through an educational program. The experiment was of a pretest-posttest control group design. Pretests and posttests on the experimental and control towns involved the use of a self-administered questionnaire which contained, among other questions, social distance and social responsibility items. In addition to these tests the experimental town was subjected to interviews before and after the educational program to discover what facts and rationalizations lay behind responses to the questionnaire. The interview used the Star case descriptions, which have since been used in numerous studies in various countries, to examine the recognition of psychiatric symptoms.

The Educational Program

The educational program, which was to serve as the treatment or agent of change, is of some interest. What was one to tell the public about mental illness? In their contact with the town, the Cummings emphasized that the "lack of an undivided body of expert opinion available on the subject made everyone's opinion valid" (1957:24). Not believing this themselves, they launched a campaign employing many of the concepts and ideas of the Mental Health Association and professional members of the psychiatric services. The Cummings' goal was to decrease the public's feelings of social distance and to increase the feelings of social responsibility for the problem of mental illness by emphasizing the following principles:

> (a) Behavior is caused and is therefore understandable and subject to change. (b) There is a continuum between normality and abnormality. (c) There is a wider variety of normal behavior than is generally realized (Cumming and Cumming, 1957:20).

In order to achieve these ends the Cummings used such methods as small group discussions, films, radio programs, and newspaper stories. In addition to this, pamphlets and books were made available at the library and speakers were brought in to talk to local associations and groups.

Although the Cummings are vague about the specific content of their educational program they do state that if the public were to accept the "causal connection" between mental illness and "long-term disturbance of interpersonal relationships" as opposed to belief that mental illness has a biological or hereditary basis, rehabilitation of the mentally ill would be easier (1957:19). The authors acknowledged the existence of biological and hereditary causes of mental illness, but they felt that the public would be more accepting of the mentally ill if they were considered to be "unfortunate in their life situation and less (so) as 'bad' or of 'inferior stock'" (1957:19). One immediately wonders about the truth and ethical implications of such an assumption. Should some people be told lies in order that other people (ex-mental patients) may benefit (i.e. be accepted)?

Data Collection

In the experimental town of Blackfoot the Cummings arranged for volunteer canvassers to deliver the questionnaires about 4pm to the adult members of each household. To minimize discussion of items and any reflection which might "jeopardize" spontaneous responses, the questionnaires were picked up after supper. The Cummings state it was not possible to know for sure how many permanent residents there were at the time of the survey, but they estimated that the 540 respondents who answered more than half of the items represented about 60% of the adult residents of Blackfoot.

In the control town of Deerville the pretest sample of 107 respondents was chosen by "calling on households selected from a serpentine path through the town"

(Cumming, 1954:146). In their book the Cummings state that the sample was random (1957:70).

On the bases of Table 3.1 Elaine Cumming concluded that the Blackfoot population scored "significantly higher" than the Deerville sample on the pretest social distance scale (Cumming, 1954:145). In their book, the Cummings note that "with this amount of difference" they could not "eliminate the possibility that it had occurred by chance alone" (1957:70). They also suggest that there may have been a selection factor operative in Blackfoot, because those who were interested may have tended to get higher scores" (1957:70). One could also speculate that a random sample gathered in a "serpentine" manner could have also introduced a "selection factor" in Deerville. For the purpose of the experiment the Cummings concluded that the experimental town did not differ "too much" from the control town. Upon examining the table the Cummings presented (see Table 3.1), one finds that while 29.9% of the Deerville sample had negative attitudes only 16.9% of the Blackfoot sample did (a difference of 13 percentage points). In terms of positive attitudes the difference between the two towns is reduced to 3.5 percentage points, with the Blackfoot respondents being more positive. Less than five times in one hundred would this difference occur by chance, yet, the Cummings felt they could not eliminate this possibility.

Table 3.1 here

Analysis of Data

The Cummings data analysis appears to be somewhat inadequate. For example, in their analysis of determinants of attitudes they present only one function, a measure of statistical independence (chi-square). This function provides neither a sign, nor a measure of strength of a relationship. Chi-square only gives an indication of how often a particular result would occur by chance. The Cummings even misuse this one function; they had no random sample in Blackfoot but had attempted to reach the entire adult population. Hirschi and Selvin state that a test of statistical significance is "meaningless unless some random phenomenon is involved. With no sample there can be no sampling error" (1973:221).

How strong is the relationship between education and social distance and between age and social distance? A measure of association or an examination of the differences in percentages could have been used to establish this fact. Table 3.2 illustrates the relationship between education and attitudinal social distance toward the ex-mental patient as presented by Elaine and John Cumming for their pretest in Blackfoot (1957:58). As the Cummings have the dependent variable (social distance) classified, there appears to be little percentage difference between categories of the independent variable. Only by collapsing categories 0-4 and 5-8 of the social distance items could a substantial difference be seen and then the greatest percentage difference was between grade school and some high school (19.8 percentage points difference); there was little difference between some high school and high school graduation or more (3.5 percentage points difference). This difference was also seen but not to as great an extent when the categories were collapsed 0-2, 3-5 and 6-8.

Table 3.2 here

Table 3.3 illustrates the relationship between age and attitudinal social distance toward the ex-mental patient as presented by the Cummings from their pretest in Blackfoot (1957:59). Again, the differences in percentages is greater when categories are collapsed.

Table 3.3 here

"The testing of theories built on causal models requires that you control for third variables" (Mullins, 1971:77). Were there any antecedent variables that could have explained away the original relationship between education and social distance and age and social distance? Were there any intervening variables that could have helped explain how age or education affected social distance? The Cummings did not address these questions.

Interpretation of Results

Comparison of social distance items before and after the six month educational program was one factor that led the Cummings to conclude that the people in "Blackfoot" (pseudonym for the experimental town) had not changed their attitudes. It should be noted that the Cummings set no standards as to what "desirable" attitudes or "desirable" change would be but from Table 3.4 it is clear that they were unsuccessful in changing the attitudes of Blackfoot residents toward the ex-mental patient.

Table 3.4 here

The Cummings concluded that the people of Blackfoot still socially and physically rejected the ex-mental patient, and remained "unwilling" to recognize psychiatric symptoms as mental illness. This last statement appears inconsistent with the Cummings' third working principle that, "there is a wider variety of normal behavior than is generally realized" (1957:20). If the respondents were "unwilling" to recognize the Star case vignettes as mental illness one would think that this was evidence that they accepted a wider variety of behavior as normal.

Another factor which led the Cummings to conclude that the people of Blackfoot still rejected the ex-mental patient was their negative reaction to the researchers attitudinal change efforts.

Upon their return to Blackfoot for the posttest interviews, the six interviewers related to the Cummings that they were met with "out-and-out hostility", fear, and avoidance (Cumming and Cumming, 1957:41-43). At one point the Mayor approached one of the interviewers, questioned him about his credentials and said, "we have had too much of this sort of thing; we are not interested in it in this town anymore. The sooner you leave the better" (Cumming and Cumming, 1957:44).

In her thesis, Elaine Cumming related another incident about a local woman who had been added to the research staff. This woman became "highly agitated and disturbed" and warned the Cummings that they would be wise to stop certain activities. She was finally "admitted in an acutely anxious condition into the psychiatric unit for intensive treatment" (Cumming, 1954:59). Elaine Cumming stated that her disturbances were probably brought on by the content of the educational program pertaining to childhood (1954:60).

The Cummings discussed other incidents of rejection - people phoned and asked to be taken off the Cummings' "list", others refused to be interviewed, the posttest response rate in Blackfoot yielded 100 fewer questionnaires than the pretest, fewer people gave data regarding their age and education, and fewer signed their names to the posttest questionnaire.

The Cummings described Blackfoot's reaction to their educational program as anxiety, manifested by apathy and withdrawal which finally "cumulated in hostility and aggression at the verbal level" (1957:46). They interpreted Blackfoot's reaction as a pattern of "denial isolation and insulation" and questioned the understanding some people had of the program. One might add that the Cummings' interpretation of the public's understanding of the program can also be questioned.

> Evidence. . . of misunderstanding lies in the spontaneous comment written across the bottom of one resurvey questionnaire: "These questions are impossible to answer coherently. Answers would depend upon mental patients in questions. I would fear an ex-patient who had committed murder or a serious sex crime, but I would not fear one who had been docile or merely suffered hallucinations or other mild forms of insanity" (Cumming and Cumming, 1957:43-44).

The Cummings' interpretation of this comment was as follows:

> In short, this was an average citizen in terms of our categories, and with his manifest lack of ability to discriminate between mild and serious forms of insanity and his tendency to associate mental illness with sex crimes and murder makes us count him a failure from the point of view of our program (1957:44).

The possible misinterpretation on the part of the Cummings seems obvious. When one refuses to answer questions about the mentally ill because the answers depend upon the type of mental patient involved - violent or more docile, one means just that. That is, because the questionnaire failed to distinguish between mild and serious forms of mental illness the person did not answer the questionnaire. How could the Cummings possibly have interpreted the man's comment as the "lack of ability to discriminate between mild and serious forms of insanity" (1957:44). In her thesis Elaine Cumming adds, that the respondent made an intelligent criticism of the scale items but displayed his low level of information about the nature of mental illness (1954:67).

The Cummings relate another example of a misunderstanding that occurred.

> One of the more enthusiastic respondents told the interviewer that he had never realized that masturbation could cause mental illness until the psychiatrist had said that it could at one of the study group meetings. Upon investigation it transpired that the psychiatrist, who remembered the incident well, had said in reply to a question that the main danger in masturbation resides in the anxiety and guilt which it engenders and that this anxiety and guilt might be related to subsequent mental illness. He recalled emphasizing this point carefully because he feared the type of misunderstanding which seems to have occurred despite his effort. Possibly even the enthusiasts were essentially ambivalent to the project, and this respondent may have been UNCONSCIOUSLY MOTIVATED to opposing the program (1957:43) (emphasis added).

Perhaps the psychiarist had unconsciously (sic) left the impression that masturbation does cause insanity.

The Cummings interpreted the hostility portrayed by the people who "ran them out of town" as "anxiety reactions". They state that these reactions were probably due to the content and method of presentation rather than "simply personal animosity".

On the return trip to Blackfoot the only two people who could recollect the original study, in any detail, would have disagreed with the Cummings' interpretation of the hostility felt by the people of Blackfoot in 1951.

CHAPTER IV. PROBLEMS WITH A RE-SURVEY

It should be noted that the 1974 re-study, Opened Ranks, which will be discussed in Chapter V, was a re-study of the Cummings' baseline towns not an exact replication. While Chapter V describes the re-study this chapter deals with some of the problems encountered, in the planning and analysis stage of the project, because of the methods used and nature of information provided by the original authors.

Measuring Social Distance

The instrument used in the 1951 Closed Ranks study was constructed by Elaine and John Cumming in a two step procedure. First, a Likert-type scale measuring "constructiveness versus non-constructiveness" was administered to student nurses. After interviewing a sample of the nurses the Cummings concluded that the six category Likert scale was measuring a personality dimension - shy withdrawn girls versus outspoken ones. Therefore they decided to use dichotomous agree-disagree answers and scaled the items according to Guttman's method. After administering the revised questionnaire to a population of civil servants they concluded that their items scaled on two dimensions, social distance and social responsibility.

Although the Cummings discussed thirty different items, while constructing their instrument they went to the field with twenty-three. Since it was difficult to determine which items they actually used, Opened Ranks 1974 used all thirty items originally presented by the Cummings in 1951.[1]

The 1974 questionnaire, somewhat different from the 1951 one, was composed of 36 items, twelve of which the Cummings referred to as social distance items.[2] The remaining items used in 1974, of no concern here, were about community psychiatry, social responsibility, etc.

Although it is difficult to determine exactly which items the Cummings used in 1951 it is known that the twelve social distance items listed in Appendix B were used in both 1951 and 1974.

Distributing the Questionnaire

In 1951 the Cummings had their questionnaires delivered to each adult member of the households in Blackfoot and selected respondents from a "serpentine path through the town" in Deerville (see Chapter III). In 1974 it was more practical to work with a random sample from each town.[3] An attempt was made to deliver the questionnaires to the Blackfoot sample as the Cummings had done but this proved to be inefficient because of the difficulties encountered trying to locate people. It was then decided to mail out the questionnaires in order to repeat the basic method of using self-response questionnaires.

In Deerville, the mailed out procedure was considered more appropriate than a "serpentine path through the town".

Problems with Data Presentation

The most impressive aspect of the Cummings' presentation of data is the lack of it. This becomes immediately apparent when one attempts to compare the results of a re-survey with their original study. Although the Star Interview was given before and after the educational program, an examination of Elaine Cumming's dissertation and Elaine and John Cumming's book does not disclose data on the posttest interview. The Cummings merely note that there was no change.

There are limitations with the questionnaire data as well. For example, it would have been interesting to compare the responses to individual questionnaire items in Blackfoot and Deerville in 1951. This is impossible because the Cummings provided the results of responses to individual items for the 540 subjects in Blackfoot but only presented summary results of the social distance scale for the 107 cases in Deerville. In 1974 we were able to look at individual questionnaire items in both Blackfoot and Deerville and it would have been desirable to make similar comparisons with the 1951 data.

In addition to the results discussed above the Cummings produced a number of Guttman scales from their pretest and posttest questionnaire items in Blackfoot and Deerville. They presented the social distance items which scaled for the following: pretest and posttest in Blackfoot (8 and 6 items respectively); and the posttest for Deerville (7 items). In addition, they presented five core items which scaled on both the pretest and posttest in both towns. No coefficients of scalability were given while reproducibility coefficients of over .90 were given for the core items in the posttests in both towns. Upon rescaling these social distance items in 1974 no Guttman scale emerged with a reproducibility coefficient of greater than .88. The core items of 1951, those which scaled in the first and second survey in both towns (see items 10, 12, 8, 11, and 9, Appendix B), had reproducibilities of over .90 in 1951. The same items in 1974 had reproducibility coefficients of .86 in Blackfoot and .88 in Deerville; and scalability scores of .62 and .67 respectively. There was also a reversal of the first two items in Blackfoot but not in Deerville. That is, in 1974, in Blackfoot, the "falling in love" item preceded the "discourage our children from marrying" question.

Attempting to follow the Cummings' reasoning from here is difficult. While the Cummings list their five "core items" (those which "scaled in the survey and the resurvey in both Blackfoot and Deerville") (Cumming and Cumming, 1957:178), they use six unidentified items when they compare Deerville and Blackfoot because "only six items were scalable in Blackfoot and Deerville on both the first and second questionnaires" (Cumming and Cumming, 1957:75).

For the town of Deerville the Cummings list the seven items which scaled in the posttest but then for the purpose of analysis they use the six items that scaled in the pretest (or the "core items"; it is difficult to determine which) without ever saying which six items were used.

The reader may ask why social distance is being measured in so many different ways. Naturally it would have been desirable if the same set of questionnaire items could have been used in both samples. Unfortunately, as indicated above, this was not the case. Therefore, can we assume that the eight item scale in Blackfoot and the six item scale in Deerville were valid measures of social distance? Although slightly different it seems reasonable to assume that they were measuring essentially the same thing. The same question applies to the measurement of social distance in 1974.

Although there was a slight change in the ordering of the scale items in Blackfoot in 1974 there is good reason to believe that the same item scale is a valid and comparable measure of social distance in Blackfoot in 1951 and 1974.

In Deerville the Cummings used a six item scale in 1951 but did not tell us which six items were used. It was possible to determine five of the items and make a reasonable guess at the sixth. Therefore, in 1974 we used the same six items that we believe were used in 1951. We were willing to assume that the same items used in 1951 and 1974 were measuring essentially the same phenomenon - attitudinal social distance toward the ex-mental patient. Furthermore, we will assume that the eight item and six item scales can be used for purposes of comparison.

Sketchy data presentation from the 1951 study hampered the analysis of changes in the correlation between demographic variables and attitudes. For example, it would have been interesting to compare correlates of attitudinal social distance between Blackfoot and Deerville in 1951 and determine whether or not there had been any change in these correlates from 1951 to 1974. Unfortunately the Cummings did not present any such data for Deerville 1951. Owing to a "regrettable administrative error", the Cummings' 1951 questionnaire did not ask for the sex of the respondent; therefore, sex comparisons between 1951 and 1974 are not possible.

Summary

Despite the problems, associated with comparing attitudinal social distance, from one community to another and between 1951 and 1974, we feel confident that the measures used in 1951 and 1974 were measuring essentially the same thing. Furthermore, the way demographic variables were analyzed in 1951 complicated the 1974 analysis. However, in Chapter VI we were able to present data from 1951 and 1974 in such a manner as to shed light on the hypotheses stated in Chapter I.

Footnotes

1. Although at one point the Cummings list 23 items (1957:172-173) it is still unclear exactly which items were used. After listing the 23 items they state that all the items used in the pretest were used in the posttest. In addition, two new responsibility items were added to the posttest "to fall logically between those dealing with responsibility at the community level and those dealing with it at the close kinship level" (1957:174). For illustration they list eighteen items; out of these eighteen there were six, not two, that did not appear in the list of 23 items.

2. A thirteenth social distance item, similar to one of the twelve social distance items used by the Cummings was added. This last item asked whether respondents were willing to work "with" someone who had been mentally ill as opposed to working "for" someone who had been mentally ill, as the Cummings had asked the question. This last item was added in order to compare results with some of the studies subsequent to 1951 which had reworded the question.

3. The interview and self-response questionnaires were administered within a short time period in Blackfoot. It was thought, and later substantiated, that residents

would not appreciate being surveyed twice on the same subject matter which involved seemingly similar questions.

CHAPTER V. OPENED RANKS: THE 1974 RE-STUDY

"Opened Ranks? Closed Ranks Revisited"[1] re-examined some of the questions concerning public opinions and attitudes about mental illness by returning to the two Saskatchewan towns that were the objects of Elaine and John Cumming's research and educational efforts in 1951. Opened Ranks, carried out in 1974, had some of the following objectives: (1) to determine to what extent, if any, public recognition of psychiatric symptoms had changed; (2) to explore changing public conceptions of mental illness; (3) to determine to what extent public attitudes toward the mentally ill, in terms of social distance, remained the same or changed; (4) to determine to what extent feelings of responsibility toward the mentally ill, had remained the same or changed; (5) to explore public reactions to changes in the delivery of psychiatric health care (i.e. community psychiatry); (6) to determine to what extent the public rejects the mentally ill as opposed to socially disruptive behavior; (7) to examine the determinants of public recognition of psychiatric symptoms; and (8) to examine the determinants of attitudinal social distance toward the ex-patient (D'Arcy, 1975). This thesis deals with only the social distance items in both Blackfoot (pseudonym for the Cummings' experimental town) and Deerville (pseudonym for the original control town) and will not explore objectives 1, 2, and 4 through 8.

The Communities

The Cummings' experimental town of Blackfoot appears to have changed little in the last quarter century. The 1951 census showed a larger proportion of older people in the town of Blackfoot in comparison to the province as a whole, as did the census in 1971. In 1951, 9% of the population of Blackfoot was over 70 years of age compared to 5% for the provincial population; in 1971, 14% was over 70 compared to 7% for the province. While the proportion of people 25-44 decreased from 25.3% in 1951 to 15.5% in 1971, the proportion of people over 65 increased from 13.7% to 19.3%. Essentially Blackfoot grew a bit older. There were slightly more females than males in Blackfoot in both census years (52.2% in 1951 and 50.8% in 1971).

The educational attainment for the town has increased over the years. In 1951, 51.6% of those not attending school had less than a grade nine education; this was reduced to 29.8% by 1971. More detailed comparisons are limited by the changes in census categories over the years.

In 1951, 87% of the population was Protestant and 13% was Catholic; by 1971, 76% of the population was Protestant and 25% was Catholic. In both census years the predominant ethnic group was British (73.6% in 1951 and 67.1% in 1971). Elaine Cumming described the 1951 town as "wealthy, proud, and conservative" (1954:28); a conservatism derived from the British rather than the American tradition. In 1974, the town, with its still many attractive homes and well kept lawns, has lived up to its traditional name, "Blackfoot, the Beautiful".

The Cummings' control town of Deerville has changed in the same manner. In 1951, 11% of the population of Deerville was over 70 years of age compared to 14% in 1971. The town also had slightly more females than males in both census years (52.4% in 1951 and 50.4% in 1971).

The educational attainment for the town has increased in the last two decades. In 1951, 47.6% of the population had less than a grade nine education compared to 31.0% in 1971.

In 1951, 94% of the town was Protestant and 6% was Catholic; by 1974, 84% was Protestant and 16% was Catholic. In both census years the predominant ethnic group was British (84.4% in 1951 and 69.2% in 1971).

Research Instruments

Opened Ranks involved the use of three different research instruments, all of which have been used in other studies.

First, the question of public recognition of psychiatric symptoms was measured using a semi-structured interview schedule developed by Dr. Shirley Star for her 1950 national U.S.A. study. This standard interview was used by the Cummings in Saskatchewan and has since been used in numerous studies in the last twenty-five years.

The second instrument, the Opinions about Mental Illness Scale (OMI) was also used. This questionnaire is composed of factor analytically derived Likert-type scales (Cohen and Struening, 1963).

The major self-administered instrument used was similar to the original Cummings' study questionnaire (see Chapter IV). It was designated to measure public attitudes toward the mentally ill in terms of social distance, social responsibility, and community psychiatry.

Again, this thesis is concerned with only the social distance items from the major self-administered instrument.

Research Procedures

The same two southern Saskatchewan towns were the focus of the 1974 Opened Ranks study; in the Cummings' work they were given the pseudonyms Blackfoot (Indian Head) and Deerville (Moosomin).

During July and August 1974 a fifteen percent random sample from the town of Blackfoot was interviewed. The 104 completed interviews represented 71% of the available sample.

The self-administered questionnaire, which included the social distance items of concern here, was given to an independent twenty percent random sample of the adult population of Blackfoot.

In the second town, Deerville, a twenty percent random sample of the adult population was drawn from the voters' list. Both the social distance questionnaire and the OMI questionnaire were administered to a random sample of the adult population in a split-half fashion; with odd numbered subjects receiving the OMI and even numbered subjects the social distance questionnaire.

Since this thesis is concerned with only the social distance items which were administered to Blackfoot and Deerville we will dispense with any further discussion of the Star interview schedule or the OMI.

The samples involved in this study were drawn from the voters' list compiled for the federal election in July 1974.[2]

The questionnaires were mailed out with a letter of introduction from the project director, a stamped self addressed return envelope and a stamped self addressed "Completion Notification Card", which was to be returned separately indicating that the respondent had completed and mailed in the questionnaire.

Persistent follow up procedures were used. There was a follow up letter two weeks later. One week after that a replacement questionnaire package was mailed out. After another three weeks a final third questionnaire was mailed out to non-respondents. The procedure involved is similar to the procedure reported by Dillman _et al._ (1974). This mail out procedure, in contrast to the usual mail out procedure, produces relatively high rates of return.[3]

Responses Rates and Sample Characteristics

The initial sample in Blackfoot of 243 persons were mailed questionnaires. In terms of the response rate, 17 of those sampled had moved, died, couldn't write English, etc. Of the remaining 226, 32 refused to answer the questionnaire and 58 did not respond to the mailed solicitations. One hundred and thirty-six useable questionnaires were returned comprising 60% of the available sample.

Of the 317 persons in the town of Deerville who were initially mailed questionnaires sample decay comprised 31 individuals. Of the remaining 286 individuals, 20 refused to answer the questionnaire, and 79 individuals did not respond. One hundred and eighty-seven useable questionnaires were returned comprising 65% of the available sample. Ninety-seven were of the OMI type and 90 were the social distance type.

Females were over represented in the obtained samples for both towns. In Blackfoot 56.6% of the sample which returned usable questionnaires was female while only 53.0% of the population over 20 was female. In Deerville 60% of the sample was female while only 52.7% of the population was female.

In both samples the over 70 age group was underrepresented. According to the Saskatchewan Hospital Services Plan Covered Population (1974) 22.1% of the Blackfoot population over 20 was over 70 but only 14.8% of the Blackfoot sample was over 70. In Deerville 21.2% of the population over 20 was over 70 while only 11.1% of the sample was over 70. The lower representation of the older population could be due, in part, to the fact that Blackfoot has two senior citzens' homes and Deerville has one. A larger proportion of the older people could have been unable to answer the questionnaire.*

Individuals with more formal education were slightly over represented in the obtained samples for both towns.

It is difficult to judge whether or not ethnic groups or religious groups were under or over misrepresented in the samples because of high number of respondents who choose not to give this information.

Only the portion of the Opened Ranks study relevant to this thesis, that is, the self-administered social distance questionnaire will be analyzed in Chapter VI to assess changes in attitudes over the last 23 years.

Footnotes

1. This project was supported in part by funds from the Psychiatric Services Branch of the Saskatchewan Department of Health and from a research grant from Mental Health Saskatchewan and Associated Canadian Travellers. Carl D'Arcy, a research sociologist at the Applied Psychiatric Research Unit, University Hospital, Saskatoon, was the director of the project.

2. The voters' list for the town of Blackfoot consisted of 1207 individuals over eighteen years of age and eligible to vote in the July federal election and the list for the town of Deerville consisted of 1548 individuals. These voters' lists were the universe from which the study samples were drawn.

3. The questionnaire mail outs and returns occurred during June till September, 1974 for the town of Deerville. In the town of Blackfoot the questionnaire mail outs did not occur until the interviews had been completed. The Blackfoot questionnaire mail outs and returns occurred during late August till eary December 1974.

4. In the Blackfoot interview sample of 188 people, one could not speak English and seven were too old or too

sick to be interviewed.

CHAPTER VI. DATA ANALYSIS

Changes in attitudinal social distance over time can be examined by comparing the Cummings' 1951 study results with our 1974 results. In Blackfoot an item by item analysis and a summary scale are used to examine changes, while in Deerville, only a summary scale is possible (see Chapter IV). For the purpose of examining the correlates of attitudes two different methods are used for measuring the same phenomenon - attitudinal social distance. First, social distance is measured using a method identical to the Cummings; the number of favorable responses out of eight social distance items is used (see Appendix C and Chapter IV). Secondly, a more general measure of social distance is obtained by creating an index which includes all of the eight items used by the Cummings in their analysis of determinants plus five other social distance items (see Appendix B).

Attitudinal Social Distance, 1951-1974

When examining changes in public attitudes over approximately twenty-five years, a direct comparison between the Cummings' 1951 and the 1974 data results seems most appropriate. However, one is limited by the amount and type of data presented in the original study (see Chapter IV).

Blackfoot. For Blackfoot the Cummings presented the percentage of subjects responding in a positive fashion to twelve social distance items (see Appendix B).[1] It is assumed that the same items used in 1951 and 1974 were measuring essentially the same phenomenon - attitudinal social distance, and are therefore comparable in assessing the percentage of the populations responding in a favorable manner.

Proposing a substantive hypothesis that attitudes have become more accepting in Blackfoot 1974 a one-tailed difference of proportions test was used to establish the statistical significance of attitudinal changes. Table 6.1 shows an item by item comparison of the twelve social distance questions used in both years in Blackfoot.

Table 6.1 here

There has been a statistically significant increase in the acceptance of the ex-mental patient as tenant, roommate, a person to fall in love with, someone for your children to marry, and acceptance of marriage with someone from a family in which there was mental illness. Of the five significant changes the last two are the greatest; a 23 percentage point increase in the number of people who would not discourage their children from marrying anyone who had been mentally ill and a 24 percentage point increase in a willingness to marry someone from a family in which there was mental illness. The latter question may be a function of age while the former question may be a reflection of changing cultural patterns (i.e. today parents have less say in whom their children marry).²

While the changes are not as great as the two items above, there has been an increase in the acceptance of the ex-mental patient as roommate (8 percentage points), tenant (9 percentage points), and "someone to fall in love with" (8 percentage points).

There appears to be an increasing acceptance of the ex-mental patient in more intimate roles but no significant change has occurred in the acceptance of the ex-mental patient in the following roles: one to trust with financial matters or lend money to, office partner, employer, babysitter, clubmember, or one to sell an adjoining lot to.

In addition to an item by item analysis the Cummings developed a summary scale composed of eight social distance items (see Appendix C). We did the same and have classified the respondents into negative, neutral and positive categories. Comparing people in 1951 and in 1974 one finds that they have shifted away from the neutral response (see Table 6.2). There was also a 10.6 percentage point increase in the number of individuals responding in a positive manner.

Table 6.2 here

An overall view leads one to conclude that there are some changes in verbally expressed attitudinal social distance in Blackfoot. However, the magnitude and extent of change is less than what a conventional reading of the literature would suggest.

Education, age and social distance. Upon analyzing the eight item social distance scale in Blackfoot, the Cummings found that attitudes varied directly with education and inversely with age. In order to determine whether or not age and education were still related to attitudes in Blackfoot, attitudes were again trichotomized as in Table 6.2. Table 6.3 shows that the relationship between education and social distance, in 1951, was statistically significant at the .001 level and had a gamma value of .24. While the gamma value for the relationship between education and social distance was .30 in 1974 the smaller sample size resulted in a smaller Chi Square which was significant at the .10 level. Although there is a greater chance that the 1974 gamma of .30 could have been the result of measurement error it is more logical to assume that the better educated people still have more favorable attitudes toward the mentally ill than the less educated.

Table 6.3 also suggests that in 1974, as in 1951, the higher score associated with higher education is accounted for mainly by the difference between "grade school only" and higher education. While the difference between grade school and some high school, in responding in a positive manner was 25.3 percentage points in 1974 (18.5 in 1951) the difference between some high school and high school graduation or more was only 1.4 percentage points (2.7 in 1951). On the other end of the scale 26% of those with grade school responded in a negative fashion in 1974 compared to 21.2% with some high school and 11.4% with high school graduation or more. In 1951 the Cummings concluded that "the decision to go to high school (was) critically related to attitudes toward mental illness" (Cumming and Cumming, 1957:74).

Table 6.3 here

By comparing similar cells between 1951 and 1974 in Table 6.3 one sees that in all three education categories the shift over 23 years was to the positive category. There was a greater positive shift for individuals with high school graduation or more and some high school than there was for those individuals with grade school only. In 1951, 45.8% of those people with high school graduation or more had positive attitudes; by 1974 this had increased to 59.0% (an increase of 13.2 percentage points). Those with some high school increased from 43.1% to 57.6% - a 14.5 percentage point increase, while the grade school category had increased only 7.7 percentage points. There was a slight increase in negative attitudes of 1.9 and 3.6 percentage points for the grade school and those with some high school categories over the years while the negative category for those people with high school graduation or more remained unchanged.

Table 6.4 demonstrates that age was still related to attitudes in 1974. While only 4.4% of those under 40 had negative attitudes toward the ex-mental patient 24.8% of those over 40 had negative attitudes a difference of 20.4 percentage points. While 66.7% of those under 40 had positive attitudes only 43.4% of those over 40 responded in this manner. A difference of 23.3 percentage points. This relationship between age and attitudinal social distance was significant at the .01 level and had a gamma value of -.48. Since the gamma was -.45 in 1951, it seems that the relationship is a persistant one.

Table 6.4 here

Upon comparing similar cells between 1951 and 1974 in Table 6.4 one sees that the major change for the under 40 group was at the positive end of the scale (from 52.8% to 66.7%). In the over 40 age group the major changes were a decrease of 18.5 percentage points in the neutral category (49.8% to 31.3%) and a 17 percentage point increase in the positive category (from 26.3% to 43.3%). The major changes seem to be an increase in positive attitudes as opposed to a decrease in negative attitudes.

One might also ask if those people over 40 today (a rough proxy for those under 40 in 1951) have more negative attitudes than those under 40 in 1951. A comparison of responses for the group of respondents over 40 in 1974 with the group who were under 40 in 1951 is indeed supportive of the notion that attitudes (negative) are influenced by the aging process. In 1951 11.3% of those under 40 had negative attitudes and in 1974 24.8% over 40 had negative attitudes.

The third table the Cummings presented on demographic data, instead of controlling for a third variable, compared the extreme categories of respondents - oldest, least educated with the youngest, most educated. As is to be expected the younger, better educated still had more positive attitudes in 1974.

One could conclude from the above analysis that age and education are still related to attitudinal social distance in Blackfoot. A more detailed analysis of the interaction effects of demographic variables will be discussed later in this chapter.

Deerville. An item by item comparison in Deerville is not possible since the 1951 data on the number of subjects responding in a positive manner to any particular item is not given. The only data presented by the Cummings on Deerville is a summary social distance scale composed of six of their original twelve social distance items.[3] Therefore we used what we believed to be the same six items to make a summary scale in 1974. Table

6.5 suggests that the shift in attitudes toward the ex-mental patient in Deerville has been away from the negative and toward the positive category. There was a 20 percentage point increase in the number of individuals responding in a favorable manner (from 17.8% to 37.8%) and a 19 percentage point decrease in the number of individuals responding in a negative manner (from 46.7% to 27.8%).

Table 6.5 here

In summary, attitudes toward the ex-mental patient were more favorable in 1974 than in 1951 in both Blackfoot and Deerville.

Comparison of Blackfoot and Deerville, 1974.

The Cummings found in their pretest that the residents of Blackfoot scored higher than their Deerville sample (see Chapter III). Upon comparing the social distance items in Deerville and Blackfoot 1974 one finds no statistically significant or substantial difference emerging (see Table 6.6). Therefore it seems reasonable to combine the 136 cases in Blackfoot with the 90 cases in Deerville for further analysis.

Table 6.6 here

Another Measure of Social Distance

In addition to the eight item scale used in Tables

6.2 through 6.4 an expanded index of social distance was created using five additional items (see Appendix B).* While both the eight item scale and the thirteen item index are are measures of social distance it was felt that a thirteen item index would give a more complete measure of social distance than the eight item scale developed in 1951. Since Table 6.6 demonstrated that there was little difference between the towns of Blackfoot and Deerville in 1974 we have combined the respondents from the two towns to have a greater number of cases.

Tables 6.7 and 6.8, like Tables 6.3 and 6.4, ask if there is a relationship between age, education and attitudes toward the mentally ill. This time we are using a more general measure of social distance and will include the Deerville sample.

Age. Hypothesis four suggested that younger respondents are willing to tolerate more contact with the ex-mental patient than older respondents. Table 6.7 illustrates the relationship between age and social distance. While 35.1% of those over 40 scored negative on the social distance index, only 17.3% of those under 40 scored in this negative manner (a difference of 17.8 percentage points). While 45.3% of those under 40 scored positive on the social distance index only 34.3% of those over 40 scored in this manner. While the gamma of -.28 is not as strong as the -.45 and -.48 for the 1951 and 1974 Blackfoot sample alone the inverse relationship between age and attitudes persists.

Both methods of analysis, the eight item social distance scale and the thirteen item index, are supportive of the hypothesis that age is inversely related to attitudinal social distance toward the ex-mental patient. However, since both were measures of social distance, and the thirteen item index included the eight item scale, it would be surprising if they did not produce similar results.

Table 6.7 here

Education. Hypothesis five suggested that the more educated respondents will have more positive attitudes than the less educated respondents. Table 6.8 illustrates that while 45.1% of those with grade school scored negative on the social distance index only 31.8% of those with some high school scored in this manner and only 16.5% of those with high school graduation or more scored negative (a difference of 13.3 percentage points and 15.3 respectively). On the positive end of the index the difference is reduced to 7.0 percentage points difference between grade school and some high school and 8.7 percentage points difference between some high school and high school graduation plus. Chi-square indicates that this relationship would occur by chance eight times in one thousand.

The gamma of .29 is similar to the gamma in Table 6.3 (Table 6.3 indicated that the relationship between education and attitudes in Blackfoot, as measured by an eight item scale, had a gamma value of .30).

Again, using this analysis and the earlier analysis which used the eight item social distance scale, one could conclude that the more educated are more willing to tolerate more contact with the former mental patient than the less educated. However, it should be noted that the thirteen item index included the eight item scale.

Table 6.8 here

Age and education. Hypothesis five also stated that the influence of education on attitudes would be independent of age. Analysis of the relationship between education and social distance while controlling age is hindered by the small number of cases. This should be kept in mind while examining Table 6.9. The relationship between education and attitudinal social distance is reduced slightly but shows no interaction.

The cell values for the table which illustrates the relationship between education and attitudinal social distance for the under 40 age group are too small to make any conclusive comparisons between the categories of education. The original gamma was reduced to .22 from .29

for the under 40 age group.

For the over 40 category the difference between some high school and high school graduation plus appears to be greater than the difference between grade school and some high school. While 45.5% of those with grade school scored negative on the social distance index only 37.8% with some high school and 20.5% with high school graduation plus scored in this manner (differences of 7.0 and 17.3 percentage points). The differences on the positive end of the scale were reduced to 8.3 and 5.3 percentage points respectively. The original gamma of .29 was reduced to .25 for the over 40 age group. It should be noted, again, that this relationship shows no interaction. That is, the relationship between education and attitudinal social distance appears to persist when controlling for age even though the samplesize is smaller

Table 6.9 here

Sex. Hypothesis six, which stated that sex would not be related to attitudinal social distance toward the ex-mental patient was supported. The gamma value for the relationship between sex and attitudinal social distance was only .04.

Familiarity. Hypothesis seven stated that the more familiar the respondents are with people who had been mentally ill the more accepting their attitudes would be.

The following two questions were asked at the end of the 1974 questionnaire: "have you ever known anyone who was in a mental hospital or a psychiatric unit of a general hospital?" and "have you ever visited a mental hospital or a psychiatric unit in a general hospital?" Neither familiarity item resulted in a statistically significant correlation with attitudes toward the ex-mental patient. However, while 41.7% of those who had not known anyone in a mental hospital or psychiatric unit displayed negative attitudes on the social distance index; only 29.2% of those who had known someone scored in this negative manner (a difference of 12.5 percentage points). On the other end of the index, 25.0% of those who had not known anyone scored positive while 39.5% of those who had known someone scored in this manner. The gamma for this relationship, .26, was significant at the .19 level.

While 45.2% of those who had visited a psychiatric unit scored positive only 31.0% of those who had not visited a unit scored in this manner (a difference of 14.2 percentage points). For the negative end of the index the difference was reduced to 5.3 percentage points difference. The gamma for this relationship, .19, was signficant at the .09 level.

While there is a slight association between familiarity and attitudinal social distance the relationship is not statistically significant. Hypothesis seven, which was somewhat dubious from the start (see Chapter II), was not supported.

To summarize, these analyses suggest some improvement of attitudes toward the mentally ill over time and that age and education continue to influence such attitudes. While familiarity is related in the predicted direction, the differences are not statistically significant. Is it possible, however, that the seemingly positive change over time is mainly due to a few items on the social distance scale - items which reflect general trends over a 23 year period rather than changes that are specific to mental illness.

A More Detailed Analysis

As suggested earlier in this Chapter the response to the item which asked whether or not the respondent could imagine falling in love with someone who had been mentally ill, may have been a result of aging and the response to the item which asked whether or not the respondent would discourage their children from marrying someone who had been mentally ill, may have been the product of changing cultural patterns.

If, in response to the former question, there was a greater difference between the under 40 and the over 40 age groups than in response to the overall 13 item index one might be able to conclude that age has something to do with 'being able to imagine falling in love' rather than with attitudes toward the mentally ill. The gamma value for this item, -.49, is substantially larger than the -.28 gamma value for the relationship between age and attitudinal social distance as measured by the thirteen item index (see Table 6.7).

If the item which asked whether or not the respondent would discourage their children from marrying someone who had been mentally ill was the product of changing cultural, patterns one might expect people under 40 to be much less likely to discourage their children from marrying someone who had been mentally ill than those over 40. If in response to this item there was a greater difference between the under 40 and over 40 age groups than in response to the overall thirteen item index one might conclude that this item is a result of changing cultural patterns. Upon analyzing the relationship between age and this particular question one finds that the gamma value is -.45. Again, this is substantially greater than the -.28 gamma value for the relationship between age and social distance as measured by the index in Table 6.7.

These findings suggest that correlates of attitudinal social distance may be different when using a summary index as opposed to an item by item analysis. Is the influence of demographic variables on each item of the social distance index different? For example, is there a relationship between age, or education, and attitudes not related to marriage (i.e. finanicial matters, working conditions, etc.)?

Table 6.10a and 6.10b illustrate that while there was no relationship between age and willingness to trust someone who had been mentally ill with financial matters (gamma is .03) there was a strong negative relationship between age and willingness to marry a member of a family in which there was mental illness (gamma is -.53).

Table 6.10 here

These findings suggest that an item by item analysis of determinants of attitudinal social distance may provide additional insights. The results of such an analysis, listing the magnitude and significance of the relationships, is present in Table 6.11.

Table 6.11 here

For example, Table 6.10a is summarized in the first cell of Table 6.11. While 43.2% of those under 40 were not willing to trust ex-patients with financial matters 41.7% of those over 40 were not; a difference of 1.5 percentage points. In Table 6.11 this is shown as no difference or "none". Similarly, Table 6.10b is represented in line 5. The difference between those under 40 and those over 40 on willingness to marry into a family with mental illness is 21.3 percentage points, which is large or "high".

It is interesting to note that the three items highly associated with age are the three items pertaining to marriage (items 5, 10 and 12). If these items were removed from the social distance index the conclusions stated earlier might not be supported.

Age also appears to be related to a willingness to sponsor a person who had been mentally ill for club membership and a willingness to sell an ex-mental patient a lot beside one's house. Interestingly, age is not related to responses to questions concerned with financial matters, apartment renting, office mate, babysitter, and roommate.

The conclusion that sex is not related to attitudes toward the ex-mental patient does not change with an item by item analysis. Although there was an association between sex and willingness to marry a member of a family in which there was mental illness and willingness to trust anyone who had been mentally ill to look after children the relationship was not statistically significant (women had slightly more negative attitudes in both cases).

The earlier conclusion that the decision to go to high school affects attitudes toward the ex-mental patient is more complicated than at first appears. While there is no relationship between education and attitudes with regards to financial matters, willingness to accept the ex-mental patient as an in-law, officemate, and workmate, the relationship between education and attitudes toward the acceptance of the ex-mental patient in other roles is not uniform. However, those with some high school had more positive attitudes than those with grade school but there was no difference between those with some high school and those with high school graduation or more for the acceptance of the ex-mental patient in the following roles: someone to work for, marriage to a member of a family in which there was mental illness, clubmember, someone to sell an empty lot to, roommate, and a person to fall in love with. Respondents with some high school had less favorable attitudes than those with high school graduation or more, but there was no difference between grade school and some high school, in a willingness to rent living quarters to an ex-mental patient.

"Knowing someone who has been in a mental hospital or a psychiatric unit of a general hospital"[5] was not related to acceptance of the ex-mental patient as a person to rent an apartment to, someone to trust with children, a person to lend money to, roommate, and a person to discourage one's children from marrying. Familiarity had a high association with trusting an ex-mental patient with financial matters, medium association with willingness to sponsor a person who had been mentally ill for membership in a club and acceptance of the ex-mental patient as roommate. For other low, not statistically significant results see Table 6.11.

Earlier it was stated that the three marriage items in the thirteen item index were the only items with a strong association to age. Would an index which excluded these items still be related to age? An analysis of a ten item index shows that there is no statistically significant relationship between age and attitudinal social distance when the marriage items are excluded. The strength of the relationship is reduced to a gamma value of -.10.

A logical question follows; if we were to exclude the marriage items in the analysis of change over time would our earlier conclusion, that attitudes have improved somewhat, still be supported? Another look at the item by item analysis of Blackfoot 1951 and 1974 (see Table 6.1) indicates that the only items which showed more than a 10 percentage point increase in acceptance of the ex-mental patient (increases of 23 and 24 percentage points) were two marriage items. Further examination of the eight item social distance scale in Blackfoot 1951 and 1974 (see Table 6.2) shows that there was almost no change in the negative category (1.9 percentage points). Change in the positive category (10.6 percentage point increase in acceptance) could be explained by the fact that the two marriage items considered the most "difficult" items in 1951, according to the Guttman criteria, would by definition fall to the positive end of the eight item scale.

Our earlier finding, that attitudes toward the ex-mental patient have improved, is not substantiated if the marriage items are excluded.

In summary, the thirteen item social distance index, which incorportated the eight item social distance scale, supported the hypotheses that favorable attitudes were positively related to education, negatively related to age and not related to sex or familiarity. A more detailed analysis provided an interesting insight. The relationship between age and attitudinal social distance was reduced to an insignificant negative relation when the three marriage items were excluded from the index. It was suggested that these items may have been more relevant to aging and changing cultural patterns than attitudes toward the ex-mental patient. Further analysis substantiates the fact that attitudes toward the ex-mental patient really have not changed very much at all.

Footnotes

1. For comparative purposes we have indiscriminately used the Cummings decision as to what response was "positive" for each of the social distance items.

2. In response to this question asked about the vignettes in the Blackfoot interview a number of respondents replied, "nowadays kids marry who they want to".

3. The Cummings list only five core social distance items but in their tables they use six unspecified items. For the purposes of this analysis we assume that five of those six core items correspond to the five items they list. Since the sixth item is unidentifiable from the book or Elaine Cumming's thesis we have decided to use the following item, which scaled in the survey and resurvey: "If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill" (see Appendix D for the six items).

4. The index was constructed using the twelve social distance items which were used by the Cummings in their baseline study (see Appendix B) plus the additional social distance item. In terms of face validity the thirteen items appear to be unidimensional measuring attitudinal social distance. The variance in the

percentage of respondents replying in a positive or negative manner does not fall below 20% or exceed 80%. A Pearson correlation matrix was generated on the thirteen items and all items were kept for the index. For the purpose of index scoring a "negative" response scored one, a "positive" response three and "don't know" or no answer scored two.

5. For the sake of simplicity only one indicator of familiarity was used. Whether or not the respondent had ever known anyone who was in a mental hospital or psychiatric unit was used instead of whether or not the respondent had ever visted a mental hospital or psychiatric unit. The former indicator resulted in more negative attitudes toward the ex-mental patient.

CHAPTER VII. THE IMPACT OF RESEARCH STRATEGY ON FINDINGS

At first this appears to be just another conventional study; perhaps unique because it returned to a study area which has frequently been used as a baseline for gauging changes in public attitudes toward the ex-mental patient. There are, however, two general sets of reasons, one methodological and the other theoretical, to question some of the findings reported in the review of the literature. There are important differences in the execution and interpretation of the original Blackfoot study and subsequent studies to question whether the reported change in public attitudes is "real" or methodological. There is also a submerged theoretical issue that should be raised concerning the assumed national and even international homogeneity of public attitudes.

Methodological Problems

Methodologically there are problems surrounding the gathering and the interpretation of data. The gathering of data introduces some interesting and important questions; What method is used for collecting data? What is the nature of the population being studied? Who is gathering the data? Interpretation of the data raises another two questions; What standards are set for evaluating results? And, who is interpreting the data?

Method of gathering data. Elaine and John Cumming (1957) distributed a self-administered questionnaire to their Saskatchewan populations while many later studies used the interview method.

There are certain recognized advantages to the interview over the use the self-adminstered questionnaire and vice versa. The self response questionnaire suffers from a lower response rate and thus self selection, and from the possibility that the questions may be misinterpreted, etc. The interview is expensive, time consuming, requires more training and supervision of the field staff, etc.

Sudman and Bradburn state that self-administered questionnaries do not require "direct revelation of self to another person" and therefore one would expect them to be "less subject to problems of self-presentation than face-to-face interviews" (1974:40).

Does the interview method result in inherently different responses from the self-administered questionnaire? There is some evidence in the literature that self-administered instruments result in a greater tendency for respondents to report behavior and attitudes that present themselves in a less favorable light (Clark and Tifft, 1966; Hochstim, 1967; Thorndike, Hagen and Kemper, 1952; and Knudsen, Pope and Irish, 1967). Kahn (1952) reported that workers expressed more satisfaction with working conditions in an interview than with self-administered questionnaires. Sudman and Bradburn, who summarize some of the above studies, state that differences between self-response questionnaires and face-to-face interviews are important and that "many but not all of the differences between surveys. . . are explained by the method of administration employed" (1974:66).

McGinnis, upon scaling responses concerned with attitudes toward marriage, concluded that the "two methods resulted in drastically different placement of the same subjects with respect to the same variable" (1953:521).

The following example from the literature on attitudes toward the ex-mental patient strengthens the need for concern with method of data collection. Bentz _et al._ discovered that teachers, who responded to a self-administered questionnaire, had attitudes that were substantially more negative than a poorly educated rural population which was interviewed.

Table 7.1 shows that the differences between the interviewed public and the teachers (who responded to a self-administered questionnaire) for six social distance items ranged from 11 to 23 percentage points with an average of 19 percentage points difference; the public consistently had more favorable attitudes. For example, while 85% of those from a poorly educated rural population would be willing to sponsor a person who had been mentally ill for membership in a club or society, only 65% of the teachers would.

Table 7.1 here

These findings are contrary to all expectation. The often found relationship between education and social acceptance of the mentally ill has been positive (Cumming and Cumming, 1957; Woodward, 1951; Whatley, 1959; Phillips, 1966; Clark and Binks, 1966; Dohrenwend and Chin Shong, 1967; and Bord, 1971). Our data in Chapter VI would also support this claim. In an ex post facto attempt to explain their findings Bentz et al. suggest that perhaps teachers are more sensitive to the negative consequences of being labelled mentally ill. One obvious, but unstated, explanation is that the public responded in a more favorable manner because they were interviewed; the teachers, responding to a self-administered questionnaire, were "free" to express more negative attitudes.

The above discussion should encourage researchers to pay some attention to their method of gathering data as opposed to just attempting to find an ex post facto explanation for their results.

Interviewer effect. One advantage to the self response questionnaire is of special interest. "The questionnaire approach offers the possibility of avoiding the difference in approach so difficult to control as between one interviewer and another" (Phillips, 1971:142).

The nature of the personnel involved in some of the studies may have had some inadvertent consequences. Rabkin (1972) has noted that with the increasing rise in community psychiatry there has developed an interest in attitudes toward mental illness "especially among those who are involved in the labeling, care and treatment of mental patients (p.154). Nettler states that, "the man who can best afford to be objective about his inquiry is the man who has no vested interest in his results." (1970:101).

When Rootman and Lafave (1969) came up with some very "positive" attitudes at least one of their two interviewers was a Registered Psychiatric Nurse. Social desirability may have been operating and may account for some of the attitudinal changes.

Various studies state that bias is likely to result when there is a considerable social distance between the interviewer and the respondent (Katz, 1942; Hyman et al., 1954; and Williams, 1964). Rosenthal (1966) states that modeling effects, when found, have ordinarily been positive. That is, "the subjects' responses have tended to be similar in direction to those of the interviewer"

(1966:113). One explanation he offers is that subjects want to reduce the "perceived differences" between themselves and the interviewer, who is usually in a position of higher status (1966:114). Rosenthal also cites a report by Stember and Hyman in which interviewers inflated the number of respondents replying in a certain manner, depending on the interviewers' own position (p.337). Rosenthal goes on to say that while the mail survey does not entirely eliminate experimenter effect (the style of the introductory letter may yield different kinds of responses) at least one can specify the experimenter's stimulus (the letter) which will be similar for all respondents (1966:378).

There has been some concern in the literature about the coerciveness of the interview method of gathering data, especially in Lemkau and Crocetti's Baltimore studies. Daniel (1962), in his discussion of the 1960 study, suggests that perhaps the poorly educated sample was more likely to want to please the interviewer. To obtain an 87% response rate in Baltimore, 1970, Crocetti _et al._ were indeed persistent.

> Much effort was expended in attempting to "break" these refusals. The average number of calls for completed interviews was 2.2. For the "hard-core" refusal group, an average of 5.4 additional calls were made, as well as an untabulated number of phone calls (1974:217).

Rabkin (1974) makes the following comment with regard to Crocetti _et al._ 's 1970 study of public attitudes toward the mentally ill. She notes that, given the structure and nature of the questions asked, the results reported may merely be testimony to their "effectiveness in influencing rspondents; the questions bear within them multiple assumptions and qualifications that seem to render the interpretation of their responses somewhat uncertain" (1974:13). Again, different methods may account for some of the difference in verbally expressed attitudes.

Standards for the interpretation of data. Another methodological problem revolves around data analysis; What standards are set?

Rabkin (1974), in her review of the literature suggests that much of the data analysis has been "unsophisticated" and that findings are "presented descriptively,. . .without providing a framework within which the reader can evaluate the significance of the results or the size of observed effects" (1974:14).

How much social distance constitutes rejection? How much change is needed in order to establish that attitudes have really changed? These question have gone unanswered by researchers in the past. One exception is Crocetti and Lemkau's reply to Phillips. They refer to Bogardus' study of 1725 native-born Americans and state that, "social distance from the mentally ill is nowhere near as great as the social distance felt between native-born Americans and Negroes or even German Jews in 1928" (1965:577).

Hopefully the analysis of the literature in Chapter II has presented a framework within which readers can examine the significance of changing public attitudes.

Who is interpreting the data. The polemics surrounding the interpretation of data adds further to the confusion. Who interpretes the data and what statistics they cite can determine the overall evaluation of studies. For an explanation as to why there are divergent findings, Rabkin (1974) states that the difference seems to be between those who support a medical model of mental illness and those who relate to the social deviance model.

> These divergent evaluations of current public attitudes seem at least partly due to differences in underlying ideologies and research strategies that lead to differences in expectation regarding amount and direction of attitude change regarded as necessary or desirable (Rabkin, 1974:13).

The misrepresentations by Crocetti et al., discussed in Chapter II lead one to wonder whether researchers have been dealing with different data findings or just different interpretations of these findings.

A Framework For Understanding Survey Results

Interviews vs self-administered questionnaires. A review of the literature suggests that researchers using the interview method are finding more "accepting" attitudes than those using the self-response instrument. Table 7.2 illustrates that while 7 out of 11 studies using the interview method obtained "positive" results only 1 out of 7 studies using the self response instrument reported "positive" results.

One could place our 1974 study, reported in Chapter VI, in cell three of Table 7.2. While there had been some change in the attitudes of the people of Blackfoot and Deerville the change was not as great as a conventional reading of the literature would suggest.

Table 7.2 here

The results in Table 7.2 are consistent with Sudman and Bradburn's finding that "where a socially desirable answer is possible on attitudinal questions, there is a greater tendency to conform on personal interviews than on self-administered questionnaires" (1974:66).

Researchers. From a review of the literature it appears that there is a tendency for Mental Health Workers and Psychiatrists to report positive attitudes toward the mentally ill and for sociologists and psychologists to report negative attitudes. Table 7.3 illustrates the correlation between professional background and reported attitudes toward mental illness. While five out of six of the studies by the medical profession and mental health workers report "positive" attitudes only three out of ten studies by sociologists and psychologists report "positive" findings. One wonders whether researchers have been dealing with different data findings or just different interpretations of these findings.

Table 7.3 here

Interaction of professional background and methodology. Although the cell frequencies in Table 7.4 make any conclusions dubious one can see that the relationship between professional background and reported findings still holds when research method is controlled. This replication of results strengthens the original hypothesis that professional background is related to reported findings.

Table 7.4 here

This brief analysis of the literature supports the second hypothesis which stated that positive attitude change in 1974, as indicated by the self-response questionnaire, would be less than the changes indicated in other communities through the interview technique and more in line with the negative findings obtained from the self-response questionnaire. Hypothesis four, (see Chapter I) that there is a tendency for psychiatrists and Mental Health Workers to report positive attitudes toward the mentally ill and for sociologists to report negative attitudes, is also supported.

Theoretical Issues

Generalizations. Because results of the Star's U.S.A. National survey and the Cummings' Canadian study of two prairie towns were similar, though there was a wide disparity in the characteristics of the study population, more recent studies have assumed a homogeneity of public attitudes at the national and even continental level. However, in comparison to the Cummings' Saskatchewan town, the more recent studies have been conducted in widely different populations. Blackfoot is an older, rural and virtually all white settlement. Lemkau and Crocetti's 1960 Baltimore sample was urban, poor, uneducated, and of low social rank; 40% of the sample was Negro (unrepresentative of even the national U.S.A. population characteristics). Dohrenwend and Chin Shong's 1967 Manhattan study population was largely urban, and ethnically mixed with large percentages of Jewish, Irish, Negro and Puerto Rican respondents. Bentz and Edgerton's rural North Carolina and Virginia study population was American, two-thirds were Baptists, two thirds had less than a high school education and they were of low income, occupying largely semiskilled and unskilled jobs. The extent to which one can generalize from these populations to a Saskatchewan or even Canadian setting, and vice versa, is debatable; however, such generalizations are made.

If it is misleading to assume a homogeneity of attitudes at the community, national or international level a return to the Cummings' baseline study area seems to be one way of determining whether or not attitudes toward the ex-mental patient are "really" changing.

One other study, Rootman and Lafave's study of a small Saskatchewan town, Saltwater, at first appears to answer the question "are attitudes really changing?" Blackfoot and Saltwater were similar in age and sex distribution, were in the same province, located about the same distance from an urban centre; however, Blackfoot had a higher proportion of British descendents while Saltwater was composed of more people with German and Scandinavian origin (Rootman and Lafave, 1969:262). Rootman and Lafave's findings were similar to Crocetti _et al._'s findings and are taken to reinforce the "homogeneity" of attitudes. However, the Saltwater study was part of a larger research project which did not support the homogeneity assumption.

The idiographic factor. Idiographic, a term borrowed by Sydiaha (1969) from Gordon Allport, stresses the distinctive and characteristic features of a community as opposed to the similarites among communities. Sydiaha _et al._ (1969) tested the relative importance of the following three factors in the determination of attitudes toward mental illness: traditional culture (French vs non-French), local culture and societal culture. They concluded that. . .

> on the whole, the results obtained are most consistent with a "local culture" interpretation of community differences. Thus, most of the results. . .involved regional differences between sub-samples in the two towns. In other words, most of the statistically significant differences were obtained for sub-group comparisons between towns, rather than within towns. The implications here is that the way in which a community defines and reacts to mental illness is determined by a particular set of local historical circumstances, and that these circumstances influence most people to think and act in the same way (1969:145).

Sydiaha (1971) further substantiates the idiographic explanation with three other studies. After studying the differences between Canadian Indian and non-Indian children, Sydiaha concluded that there was a "marked differences" among the schools and that these differences were "much larger and more distinctive then were differences in ethnic or racial background" (p.390).

Sydiaha was also involved in a study of the placement of physically handicapped workers at Arvida, Quebec. He concluded that, "this placement system was eminently successful at Arvida, and less so when 'exported' to other units of the company's operations" (1971:391). Sydiaha cites a study done by Adams on T-groups in which it was found that "the pattern of association which developed in a T-group tended to be unique to that group" (p. 390).

Sydiaha compared the above examples to his finding that there were significant inter-community differences in attitudes toward mental illness.

> The impression created by these results was that every community had its own sort of conception about mental illness and its own way of dealing with it, and it really was not very sensible to try to generalize across communities in terms of obvious cultural or social parameters (Sydiaha, 1971:389).

He stresses the "idiographic" aspect of these studies, implying community uniqueness as opposed to the "nomothetic" aspect which implies similarities. (Nomothetic in this case is synonymous with homogeneous).

Blackfoot, 1974 and Saltwater, 1965

As Table 7.5 suggests, attitudes in Blackfoot 1974 are not as positive as attitudes in Saltwater. Three out of four items resulted in statistically significant and substantial differences in the two towns. While 68% of the Saltwater sample could imagine themselves falling in love with someone who had been mentally ill, only 40% of the Blackfoot sample could (a difference of 28 percentage points). 78% of the Saltwater sample would be willing to room with someone who had been mentally ill, while only 52% of the Blackfoot sample would (a difference of 26 percentage points). While 93% of the Saltwater sample would not hesitate to work with someone who had been mentally ill only 77% of the Blackfoot sample responded in this manner (16 percentage points difference). The only item the two towns did not differ on was the item concerned with discouraging one's children from marryng someone who had been mentally ill. On the one hand, this may seem to support an idiographic hypothesis, on the other hand, it may be a prime illustration of the impact of different methodological tactics - interview as opposed to questionnaire.

Table 7.5 here

Although the above analysis does not allow one to reach any decisive conclusion about the idiographic factor or the importance of the type of research instrument used it does suggest that more attention be paid to these factors in future surveys.

Recapitulation

This thesis has examined changing attitudinal social distance toward the ex-mental patient, correlates of these attitudes and the implications research methods and tactics have on research findings.

There has been some debate in the literature as to whether or not the public is more accepting of the ex-mental patient today than it was two or three decades ago. A detailed analysis of standard social distance items reported in various studies suggest that there is a common trend toward more tolerant attitudes but there is a wide variance in the magnitude of changes reported.

In order to look more closely at the extent to which public acceptance had changed, the Cummings' 1951 Closed Ranks study area was re-examined, using essentially the same research instruments and tactics.

The findings show no dramatic change in the public attitudes toward the ex-mental patient. However, there were some changes. Out of twelve items there were statistically significant increases in five: the acceptance of the ex-mental patient as tenant, roommate, a person to fall in love with, a person for your children to marry, and a willingness to marry a member of a family in which there was mental illness. However, of these five significant changes only the last two are of a substantial magnitude. An overall view leads one to conclude that verbally expressed attitudinal social distance toward the ex-mental patient has changed somewhat in the direction of increasing public acceptance of the mentally ill; though the order of magnitude of the change is less than what a conventional reading of the literature would suggest.

The often found negative relationship between age and attitudinal social distance toward the ex-mental patient was at first substantiated. However, a more detailed analysis showed that the three items pertaining to marriage were highly associated with age and when they were excluded from the index there was no longer a relationship between age and attitudinal social distance.

An additional analysis of attitudinal change over time, excluding the marriage items, did not substantiate our earlier conclusion that attitudes toward the ex-mental patient had improved in the last 23 years. Indeed, attitudes toward the ex-mental patient had not really changed.

Sex as hypothesized, was not related to attitudes.

Moderate education makes people more willing to work with someone who has been mentally ill, marry a member of a family in which there is mental illness, sponsor an ex-mental patient in a club and sell an empty lot to an ex-mental patient.

Familiarity increases willingness to trust, sponsor in a club and work with an ex-mental patient.

An analysis of the literature on attitudes toward the ex-mental patient suggests that researchers using the interview method are finding more "accepting" attitudes than those using the self-response instrument. There is a tendency for psychiatrists and mental health workers to report positive attitudes and for sociologists and psychologists to report negative attitudes. Hence, the former are more inclined to recognize "change" than the latter.

APPENDIX A

Introductory Letter to Deerville and Blackfoot

Marcotte Research Centre,
410 Cumberland Avenue,
Saskatoon, Saskatchewan

Dear

We are presently engaged in looking at various aspects of the general public's opinions about mental illness.*

You have been chosen on the basis of a random sample of the population of Deerville (Blackfoot) to participate in this confidential public opinion survey. Your co-operation in this regard would be gratefully appreciated.

Please read the instructions carefully before starting the questionnaire. When you have completed the questionnaire please mail it to us in the stamped self-addressed envelope provided. In addition, you will find attached to the questionnaire a "Completion notification card". We would be grateful if you would return this card separately when returning the completed questionnaire. This will indicate to us that you have completed the questionnaire. Thus you will not be further reminded concerning its completion.

Since it is your opinion we want we would appreciate if it you filled out the questionnaire without discussing it with others. Should you have any questions please do not hesitate to get in touch with us.

Again, thank you for your co-operation.

Your truly,

Project Director

---

* The letter to Blackfoot was the same except for the following addition to paragraph one: "One aspect of this study involved a personal interview. (You may have participated or you may know someone in Blackfoot who has participated in this phase of the study). The second phase of the study involves a self-administered survey of public opinion."

APPENDIX B

The Social Distance Items used in Blackfoot and Deerville in 1951 and 1974

1. I would be willing to trust someone who had been mentally ill with financial matters.

2. If I were resident owner of an apartment house I would hesitate to rent living quarters to a former mental hospital patient.

3. If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill.

4. I wouldn't work for anyone who had been mentally ill.

5. I would marry a member of a family in which there is mental illness.

6. I would never trust anyone who had been mentally ill to look after my children, even for a short period of time.

7. I would not lend money to a person who had been mentally ill.

8. I would be willing to room with a person who had been mentally ill.

9. I would be willing to sponsor a person who had been mentally ill in my favorite club or society.

10. We should strongly discourage our children from marrying anyone who has been mentally ill.

11. If I owned an empty lot beside my house I would be willing to sell it to a former menta hospital patient.

12. I can imagine myself falling in love with a person who had been mentally ill.

13. I wouldn't hesitate to work with someone who had been mentally ill.*

* This last item was used in 1974 but not in 1951.

APPENDIX C

The Social Distance Items Which Scaled in Blackfoot in 1951.

1. We should strongly discourage our children from marrying anyone who has been mentally ill.

2. I can imagine falling in love with a person who had been mentally ill.

3. I would be willing to room with a former mental hospital patient.

4. If I were resident owner of an apartment house I would hesitate to rent living quarters to a former mental hospital patient.

5. If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill.

6. If I owned an empty lot beside my house, I would be willing to sell it to a former mental hospital patient.

7. I wouldn't work for anyone who had been mentally ill.

8. I would be willing to sponsor a person who had been mentally ill in my favorite club or society.

APPENDIX D

The Social Distance Items Used by the Cummings for Their Analysis in Deerville, 1951.

1. We should strongly discourage our children from marrying anyone who has been mentally ill.

2. I can imagine myself falling in love with a person wo had been mentally ill.

3. I would be willing to room with a former mental hospital patient.

4. If I owned an empty lot beside my house I would be willing to sell it to a former mental hospital patient.

5. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society.

6. If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill. *

* It is unclear whether or not this sixth item was the actual item used by the Cummings. For a discussion see footnote three to Chapter VI.

Table 2.1

Social acceptance of the ex-mental patient^{+}

Source Area	Date	N	Percent willing to accept the ex-mental patient as: Someone for your children to marry	Someone to fall in love with	Room mate	Rent apart-ment	Work mate	Sell adjoining lot	Sponsor in club
1. Blackfoot, Saskatchewan	1951	540	27	32	44	60	71	71	78
2. London	1956	-	21	-	-	-	92	-	-
3. Baltimore	1960	1731	46 ($p<.001$)	51 ($p<.001$)	51 ($p<.01$)	-	81 ($p<.001$)	-	-
4. Branford, Conn.	1960	300	17*	-	-	-	87* ($p<.001$)	-	-
5. Manhattan N.Y. (L)	1960-1961	87	39 ($p<.05$)	-	-	86 ($p<.001$)	-	-	86 ($p<.05$)
6. Easton, Md.	1962	100	45 ($p<.001$)	44 ($p<.01$)	55 ($p<.05$)	-	75	-	-
7. Carroll County, Md.	1962	139	37 ($p<.05$)	-	64 ($p<.001$)	-	-	-	-
8. Kentucky	1962	970	25	36	54 ($p<.001$)	-	81 ($p<.001$)	-	-
9. Saskatchewan (WP)	1962	220	41 ($p<.001$)	26	59 ($p<.001$)	-	-	66	67 ($p<.001$)

Source Area	Date	N	Someone for your children to marry	Someone to fall in love with	Room mate	Rent apartment	Work mate	Sell adjoining lot	Sponsor in club
10. N.Y. City	1963	1412	23	-	23	-	73	-	-
11. Manhattan, N.Y.	1963-1964	150	37 ($p<.01$)	-	-	54	-	-	67
12. Saltwater, Saskatchewan	1965	102	43 ($p<.001$)	68 ($p<.001$)	78 ($p<.001$)	-	93 ($p<.001$)	-	-
13. Edinburgh	1966	446	21	-	-	-	77 ($p<.05$)	-	-
14. Rural N.C. and Va.	1968	1405	52 ($p<.001$)	45 ($p<.001$)	58 ($p<.001$)	67 ($p<.01$)	85 ($p<.001$)	70	85 ($p<.001$)
15. Rural N.C. (T)	1968	396	41 ($p<.001$)	25	36	-	62	50	65
16. Philadelphia, Pa.	1968	388	41 ($p<.001$)	-	-	47	87 ($p<.001$)	-	87 ($p<.001$)
17. Baltimore (UAW) Wave I	1970	888	-	64^{**} ($p<.001$)	79^{**} ($p<.001$)	-	90^{**} ($p<.001$)	-	-
18. Baltimore (UAW) Wave II	1970	189	63^{**} ($p<.001$)	-	-	79^{**} ($p<.001$)	96^{**} ($p<.001$)	-	98^{**} ($p<.001$)
19. Alberta	1973	1000	37 ($p<.001$)	-	59 ($p<.001$)	-	73	-	-

1. Cumming and Cumming 1957
2. Belson 1957
3. Lemkau and Crocetti 1962
4. Phillips 1966
5. Dohrenwend and Chin Shong 1967
6. Meyer 1964
7. M. Lemkau 1962
8. Kentucky Mental Health Planning Commission 1964
9. Badgley, Smith and McKerracher 1966
10. Elinson, Padilla and Perkins 1967
11. Dohrenwend and Chin Shong 1967
12. Rootman and Lafave 1969
13. Maclean 1969
14. Edgerton and Bentz 1969
15. Bentz, Hollister and Kherlopian 1970
16. Ring and Schein 1970
17. Crocetti, Spiro and Siassi 1974
18. Siassi, Spiro and Crocetti 1973
19. Decision Making Information Canada Limited 1974

+ Significance is based on a one-tailed difference of proportions test.
* Phillips used social distance items on a case description of a "normal" person who had been hospitalized for mental illness.
** Responses to the question were rated on a 5 point scale. This figure includes those who were "definitely willing" and "probably willing".

L = Leaders
T = Teachers
WP = Wheat Pool Members

Table 3.1

Comparison of attitudinal social distance toward ex-mental patients in Blackfoot and Deerville, 1951.

Attitudes toward ex-mental patients	Blackfoot (N = 540)	Deerville (N = 107)
0-1 (negative)	16.9%	29.9%
2	16.3%	16.8%
3	21.1%	15.0%
4	21.5%	20.6%
5	13.2%	10.2%
6 (positive)	11.0%	7.5%
	100%	100%

Chi-square 11.19

$.05 < p > .02$

Table 3.2

Relationship between education and attitudinal social distance toward the ex-mental patient in Blackfoot, 1951.

Attitudes toward the ex-mental patient	Education Grade School (N = 142)	 Some High School (N = 234)	 High School Graduation or more (N = 131)
0 (negative)	5.5%	6.0%	2.3%
1	7.0%	5.2%	3.8%
2	11.6%	6.4%	5.3%
3	18.3%	12.4%	4.6%
4	16.8%	9.4%	19.9%
5	16.2%	17.5%	18.3%
6	12.0%	20.9%	19.8%
7	9.8%	11.1%	11.5%
8(positive)	2.8%	11.1%	14.5%
	100%	100%	100%

Chi-square 43.42

$p < .001$

Table 3.3

Relationship between age and attitudinal social distance toward the ex-mental patient in Blackfoot, 1951.

Attitudes toward the ex-mental patient	Age Under 40 (N = 239)	 Over 40 (N = 281)
0 (negative)	2.9%	6.0%
1	4.6%	6.8%
2	3.8%	11.0%
3	6.7%	17.4%
4	10.8%	16.4%
5	18.4%	16.0%
6	22.2%	14.6%
7	13.0%	8.5%
8 (positive)	17.6%	3.2%
	100%	100%

Chi-square=80.59

p<.001

Table 3.4

The percentage of positive responses to "core" social distance items in the experimental town before and after the educational program, 1951.

	Pretest	Posttest
1. We should strongly discourage our children from marrying anyone who has been mentally ill. (disagree)	27.0%	25.2%
2. I can imagine myself falling in love with a person who had been mentally ill. (agree)	31.7%	31.9%
3. I would be willing to room with a former mental hospital patient. (agree)	44.4%	45.7%
4. If I owned an empty lot beside my house I would be willing to sell it to a former mental hospital patient. (agree)	70.6%	70.3%
5. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or organization. (agree)	78.3%	74.7%

Table 6.1

Percentage of respondents answering in an accepting manner to social distance items concerning the ex-mental patient, Blackfoot 1951 and 1974.

Social Distance Item	Blackfoot 1951 (N = 540)	Blackfoot 1974 (N = 136)	Significance*	Percentage points change
1. I would be willing to trust someone who had been mentally ill with financial matters. (agree)	50%	55%	ns	5
2. If I were resident owner of an apartment house I would hesitate to rent living quarters to a former mental hospital patient. (disagree)	60%	69%	$p<.05$	9
3.If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill. (agree)	71%	72%	ns	1
4. I wouldn't work for anyone who had been mentally ill. (disagree)	71%	77%	ns	6
5. I would marry a member of a family in which there is mental illness. (agree)	42%	66%	$p<.001$	24
6. I would never trust anyone who had been mentally ill to look after my children, even for a short period of time. (disagree)	55%	57%	ns	2

Table 6.1 cont.

7. I would not lend money to a person who had been mentally ill. (disagree)	71%	75%	ns	4
8. I would be willing to room with a former mental hospital patient. (agree)	44%	52%	$p < .05$	8
9. I would be willing to sponsor a person who had been mentally ill for membership in by favorite club or society. (agree)	78%	77%	ns	1
10. We should strongly discourage our children from marrying anyone who has been mentally ill. (disagree)	27%	50%	$p < .001$	23
11. If I ownec an empty lot beside my house I would be willing to sell it to a former mental hospital patient. (agree)	71%	72%	ns	1
12. I can imagine myself falling in love with a person who had been mentally ill. (agree)	32%	40%	$p < .05$	8

* Based on a one-tailed difference of proportions test.

Table 6.2

Comparison of attitudinal social distance toward the ex-mental patient in Blackfoot, 1951 and 1974.

Attitudes toward the ex-mental patient+	Blackfoot (N = 507) 1951	Blackfoot (N = 136) 1974	Percentage points change
Negative	17.7%	19.6%	1.9
Neutral	43.6%	30.1%	13.5**
Positive	38.7%	49.3%	10.6*
	100%	100%	

+ To replicate the Cummings' method the number of favorable responses was used to establish what attitudes the public held toward the ex-mental patient. The eight social distance items used (see Appendix C) were the items that scaled in the pretest in Blackfoot in 1951. A score of 0-2 favorable items equals "negative" attitudes; a score of 3-5 favorable items equals "neutral" attitudes and a score of 6-8 favorable items equals "positive" attitudes.

* Based on a one-tailed difference of proportions test this figure is significant at the .05 level.

** Based on a one-tailed difference of proportions test this figure is significant at the .01 level.

Table 6.3

Relationship between education and attitudinal social distance toward the ex-mental patient, Blackfoot 1951 and 1974.

1951

Attitudes toward the ex-mental patient*	Education Grade School (N = 142)	 Some High School (N = 234)	 High School Graduation or more (N = 131)
Negative	24.1%	17.6%	11.4%
Neutral	51.3%	39.3%	42.8%
Positive	24.6%	43.1%	45.8%

Gamma=.24
Chi-square=19.16 p<.001

1974

Attitudes toward the ex-mental patient*	Education Grade School (N = 34)	 Some High School (N = 33)	 High School Graduation or more (N = 61)
Negative	26.0%	21.2%	11.4%
Neutral	41.2%	21.2%	29.5%
Positive	32.3%	57.6%	59.0%
	100%	100%	100%

Gamma=.30
Chi-square=8.54 p<.10

* For a description of the categories see footnote to Table 6.2.

Table 6.4

Relationship between age and attitudinal social distance toward the ex-mental patient, Blackfoot, 1951 and 1974.

1951

Attitudes toward the ex-mental patient*	Age Under 40 (N= 239)	Over 40 (N = 281)
Negative	11.3%	23.8%
Neutral	35.9%	49.8%
Positive	52.8%	26.3%
	100%	100%

Gamma=-.45
Chi-square=40.31 $p<.001$

1974

Attitudes toward the ex-mental patient*	Age Under 40 (N = 45)	Over 40 (N = 83)
Negative	4.4%	24.8%
Neutral	28.9%	31.3%
Positive	66.7%	43.3%
	100%	100%

Gamma=-.48
Chi-square=9.27 $p<.01$

* For a description of the categories see footnote to Table 6.2

Table 6.5

Comparison of attitudinal social distance toward the ex-mental patient in Deerville, 1951 and 1974.

Attitudes toward the ex-mental patient+	Deerville (N = 107) 1951	Deerville (N = 90) 1974	Percentage point change
Negative	46.7%	27.8%	18.9*
Neutral	35.5%	34.6%	.9
Positive	17.8%	37.8%	20.0**
	100%	100%	

+ To replicate the Cummings' method the number of favorable responses was used to establish what attitudes the public held toward the ex-mental patient. The six social distance items used (see Appendix D) were supposedly the items which scaled in Deerville in 1951 (see footnote 3). A score of 0-2 favorable items equals "negative" attitudes; a score of 3-4 favorable items equals "neutral" attitudes and a score of 5-6 favorable items equals "positive" attitudes.

* Based on a one-tailed difference of proportions test this figure is significant at the .01 level.

** Based on a one-tailed difference of proportions test this figure is significant at the .001 level.

Table 6.6

Percentage of respondents answering in an accepting manner to social distance items concerning the ex-mental patient, Deerville, 1974 and Blackfoot, 1974.

Social Distance Item	Deerville 1974 (N = 90)	Blackfoot 1974 (N = 136)	Significance*
1. I would be willing to trust someone who had been mentally ill with financial matters. (agree)	51%	55%	ns
2. If I were resident owner of an apartment house I would hesitate to rent living quarters to a former mental hospital patient. (disagree)	62%	69%	ns
3. If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill. (agree)	71%	72%	ns
4. I wouldn't work for anyone who had been mentally ill. (disagree)	83%	77%	ns
5. I would marry a member of a family in which there is mental illness. (agree)	67%	66%	ns
6. I would never trust anyone who had been mentally ill to look after my children, even for a short period of time. (disagree)	59%	57%	ns

Table 6.6 cont.

7. I would not lend money to a person who had been mentally ill. (disagree)	78%	75%	ns
8. I would be willing to room with a former mental hospital patient. (agree)	57%	52%	ns
9. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society. (agree)	71%	71%	ns
10. We should strongly discourage our children from marrying anyone who has been mentally ill. (disagree)	53%	50%	ns
11. If I owned an empty lot beside my house I would be willing to sell it to a former mental hospital patient. (agree)	74%	72%	ns
12. I can imagine myself falling in love with a person who had been mentally ill. (agree)	46%	40%	ns
13. I wouldn't hesitate to work with someone who had been mentally ill.	73%	77%	ns

* based on a two tailed-difference of proportions test.

Table 6.7

Relationship between age and attitudes toward the ex-mental patient in Blackfoot and Deerville combined, 1974.

Attitudes toward the ex-mental patient*	Age Under 40 (N = 75)	 Over 40 (N = 134)
Negative	17.3%	35.1%
Neutral	37.3%	30.6%
Positive	45.3%	34.3%
	100%	100%

Gamma=-.28

Chi-square=7.45

p<.02

*Attitudes are measured using a thirteen item social distance index (see Appendix B).

Table 6.8

Relationship between education and attitudes toward the ex-mental patient in Blackfoot and Deerville combined, 1974.

	Education		
Attitudes toward the ex-mental patient*	Grade School (N = 51)	Some High School (N = 66)	High School Graduation or more (N = 91)
Negative	45.1%	31.8%	16.5%
Neutral	25.5%	31.8%	38.5%
Positive	29.4%	36.4%	45.1%

Gamma=.29
Chi-square=13.74
$p < .008$

* Attitudes are measured using a thirteen item social distance index (see Appendix B).

Table 6.9

Relationship between education and attitudinal social distance controlling for age, Blackfoot and Deerville combined, 1974.

	Under 40		
Attitudes toward the ex-mental patient*	Grade School (N = 7)	Some High School (N = 21)	High School Graduation or more (N = 47)
Negative	42.9%	19.0%	12.8%
Neutral	14.3%	42.9%	38.3%
Positive	42.9%	38.1%	48.9%
	100%	100%	100%
Gamma=.22			

	Over 40		
Attitudes toward the ex-mental patient*	Grade School (N = 44)	Some High School (N = 45)	High School Graduation or more (N = 44)
Negative	45.5%	37.8%	20.5%
Neutral	27.3%	26.7%	38.6%
Positive	27.3%	35.6%	40.9%
	100%	100%	100%
Gamma=.25			

Chi-square = 11.48
.20>p>.10

* Attitudes based on the thirteen item social distance index (see Appendix B).

Table 6.10a

Relationship between age and willingness to trust someone who had been mentally ill with financial matters, Blackfoot and Deerville 1974.

Willing to trust ex-patient	Age Under 40 (N = 74)	 Over 40 (N = 127)
No	43.2%	41.7%
Yes	56.8%	58.3%
	100%	100%

Gamma=.03

Table 6.10b

Relationship between age and willingness to marry a member of a family in which there was mental illness, Blackfoot and Deerville 1974.

Willing to accept ex-patient	Age Under 40 (N = 74)	 Over 40 (N = 127)
No	14.9%	36.2%
Yes	85.1%	63.8%
	100%	100%

Gamma=-.53
$p < .002$

Table 6.11

The relationship between demographic variables and thirteen social distance items, Blackfoot and Deerville, 1974 (N = 226).

Social Distance Item	Age±	Sex	Education±±		Familiarity
1. I would be willing to trust someone who had been mentally ill with financial matters. (agree)	none (1.5)+	none (4.1)	none (5.7)	none (.4)	high* (25.6)
2. If I were resident owner of an apartment house I would hesitate to rent living quarters to a former mental hospital patient. (disagree)	none (2.5)	none (2.7)	none (1.4)	medium (16.2)	none (4.4)
3. If I were employed at a job I wouldn't hesitate to share my office with someone who had been mentally ill. (agree)	none (4.7)	none (9.9)	none (5.1)	none (1.1)	low (10.8)
4. I wouldn't work for anyone who had been mentally ill. (disagree)	medium* (15.2)	none (3.4)	low* (12.8)	none (9.2)	low (14.7)
5. I would marry a member of a family in which there is mental illness. (agree)	high* (21.3)	low++ (10.8)	medium* (18.4)	none (4.1)	low (14.8)
6. I would never trust anyone who had been mentally ill to look after my children, even for a short period of time. (disagree)	none (6.7)	low++ (13.0)	none (7.1)	low (14.8)	none (.6)
7. I would not lend money to a person who had been mentally ill. (disagree)	none (6.2)	none (5.2)	none (4.8)	none (9.0)	none (5.7)

Table 6.11 cont.

8. I would be willing to room with a former mental hospital patient. (agree)	none (2.7)	none (7.8)	low (12.8)	none (8.3)	none
9. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society. (agree)	medium* (19.0)	none (2.3)	medium* (17.9)	none (9.3)	medium (18.6)
10. We should strongly discourage our children from marrying anyone who has been mentally ill. (disagree)	high* (23.8)	none (1.2)	none (3.9)	none (6.7)	none (2.9)
11. If I owned an empty lot beside my house I would be willing to sell it to a former mental hospital patient. (agree)	low* (14.0)	none (2.8)	low* (12.8)	none (9.2)	low (13.4)
12. I can imagine myself falling in love with a person who had been mentally ill. (agree)	high* (25.9)	none (9.7)	low (11.8)	none (7.3)	low (12.1)
13. I wouldn't hesitate to work with someone who had been mentally ill. (agree)	none (2.6)	none (5.5)	none (3.3)	none (7.2)	medium* (16.1)

± Respondents were divided into those who were under 40 years of age and those who were over 40.
±± The first figure indicates the difference between those with grade school and some high school; the second figure indicates the difference between respondents with some high school and those with high school graduation or more.
* p .05
none = under 10 percentage points difference between categories
low = 10-15 percentage points difference between categories
medium = 16-20 percentage points difference between categories
high = 21 or more percentage points difference between categories

Table 7.1

Comparison of attitudinal social distance between a poorly educated rural population and teachers.

	Rural (N= 1405) (Interview)	Teachers (N= 396) (Self-Response)	Percentage points difference
1. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society. (agree)	85%	65%	20
2. I would not hesitate to work with someone who had been mentally ill. (agree)	85%	62%	23
3. If I owned an empty lot beside my house, I would be willing to sell it to a former mental hospital patient. (agree)	70%	50%	20
4. I would be willing to room with someone who had been a patient in a mental hospital. (agree)	58%	36%	22
5. We should strongly discourage our children from marrying anyone who had been mentally ill. (disagree)	52%	41%	11
6. I can imagine myself falling in love with a person who had been mentally ill. (agree)	45%	25%	20

7

Table 7.2

The influence of research method on reported attitudes toward mental illness.

	Method	
Reported Attitudes	Interview	Self-response
Positive	Woodward (1951) Lemkau and Crocetti (1962) Meyer (1964) Rootman and Lafave (1969) Crocetti *et al*. (1971) Ring and Schein (1970) Edgerton and Bentz (1969)	Bentz and Edgerton* (1970)
	7 (64%)	1 (14%)
Negative	Phillips (1963) Phillips (1967) Blizard (1970) Floyd and Roman (1971)	Cumming (1954) Nunnally (1961) Lamy (1966) Crumpton *et al*.(1967) Tringo (1970) Bentz, Hollister and Kherlopian** (1970)
	4 (36%)	6 (86%)

* Leaders

** Teachers

Table 7.3

The influence of professional background on reported attitudes toward mental illness.

	Researcher	
Reported Attitudes	Sociologist/ Psychologist	Mental Health Worker/ Medical Doctor
Positive	Edgerton and Bentz+ * (1969) Rootman and Lafave++ ** (1969) Bentz and Edgerton± + (1970)	Lemkau and Crocetti+++ (1962) Meyer (1964) Tershakovec (1964) Ring and Schein (1970) Crocetti, Spiro and Siassi+++ *** (1971)
	3 (33%)	5 (83%)
Negative	Cumming++ **** (1954) Nunnally (1961) Phillips (1963) Phillips (1967) Blizard (1970) Floyd and Roman (1971)	Bentz, Hollister and Kherlopian±± +++ (1970)
	6 (67%)	1 (17%)

+ With a department of psychiatry.
++ Combination of social sciences and medicine - social science predominant.
+++ Combination of social sciencs and medicine - medicine predominant.

± Leaders
±± Teachers

* This study was also reported in Bentz, Edgerton and Kherlopian, 1969.
** This study was also reported in Rootman, 1972.
*** This study was also reported in the following papers: Crocetti, Spiro and Siassi, 1971; Siassi, Spiro and Crocetti, 1973; Spiro, Siassi and Crocetti, 1972; and Spiro, Siassi and Crocetti, 1974.
**** This study was also reported in Cumming and Cumming, 1957.

Table 7.4

The relationship between professional background and reported findings while controlling research method.

Interview Method

Researchers

Reported Findings	Sociologist/ Psychologist	Mental Health Worker/ Medical Doctor
Positive Attitudes	Edgerton and Bentz(1969) Rootman and Lafave (1969) 2	Lemkau and Crocetti (1962) Meyer (1964) Crocetti *et al.* (1971) Ring and Schein (1970) 4
Negative Attitudes	Phillips (1967) Phillips (1963) Blizard (1970) Floyd and Roman (1971) 4	0

Self-Response Method

Researchers

	Sociologist/ Psychologist	Mental Health Worker/ Medical Doctor
Positive Attitudes	Bentz and Edgerton (1970) 1	0
Negative Attitudes	Cumming (1954) Nunnally (1961) 2	Bentz, Hollister and Kherlopian (1970) 1

Table 7.5

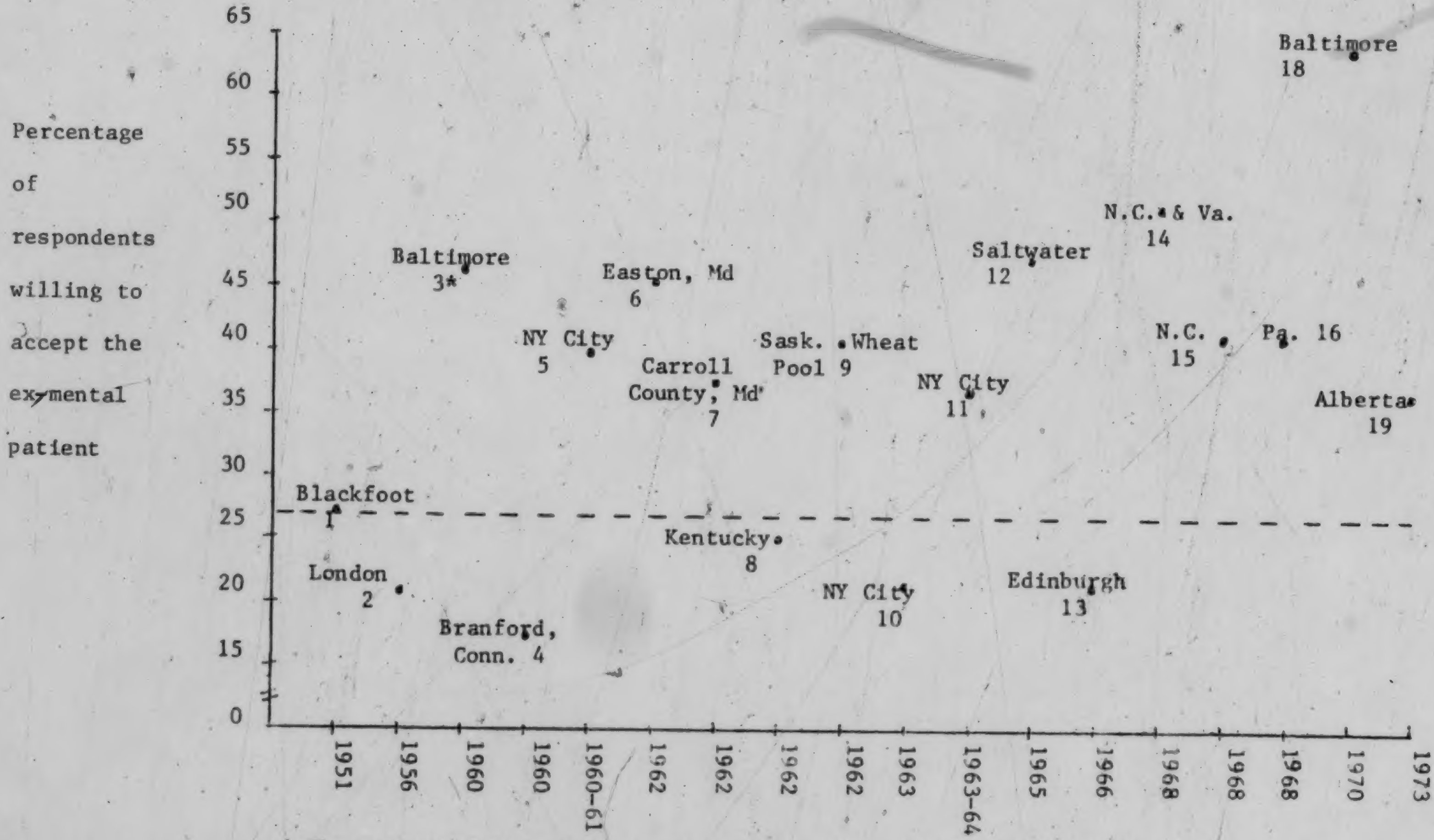
Percentage of respondents answering in an accepting manner toward the ex-mental patient, Saltwater 1965 and Blackfoot 1974.

	Saltwater 1965 (N = 102)	Blackfoot 1974 (N = 136)	Percentage points difference
1. I can imagine myself falling in love with a person who had been mentally ill. (agree)	68%	40%	28*
2. We should strongly discourage our children from marrying anyone who has been mentally ill. (disagree)	48%	50%	2
3. I would be willing to room with someone who had been a patient in a mental hospital. (agree)	78%	52%	26*
4. I wouldn't hesitate to work with someone who had been mentally ill. (agree)	93%	77%	16*

* Based on a one-tailed difference of proportions test this figure is significant at the .001 level.

Figure 2.1

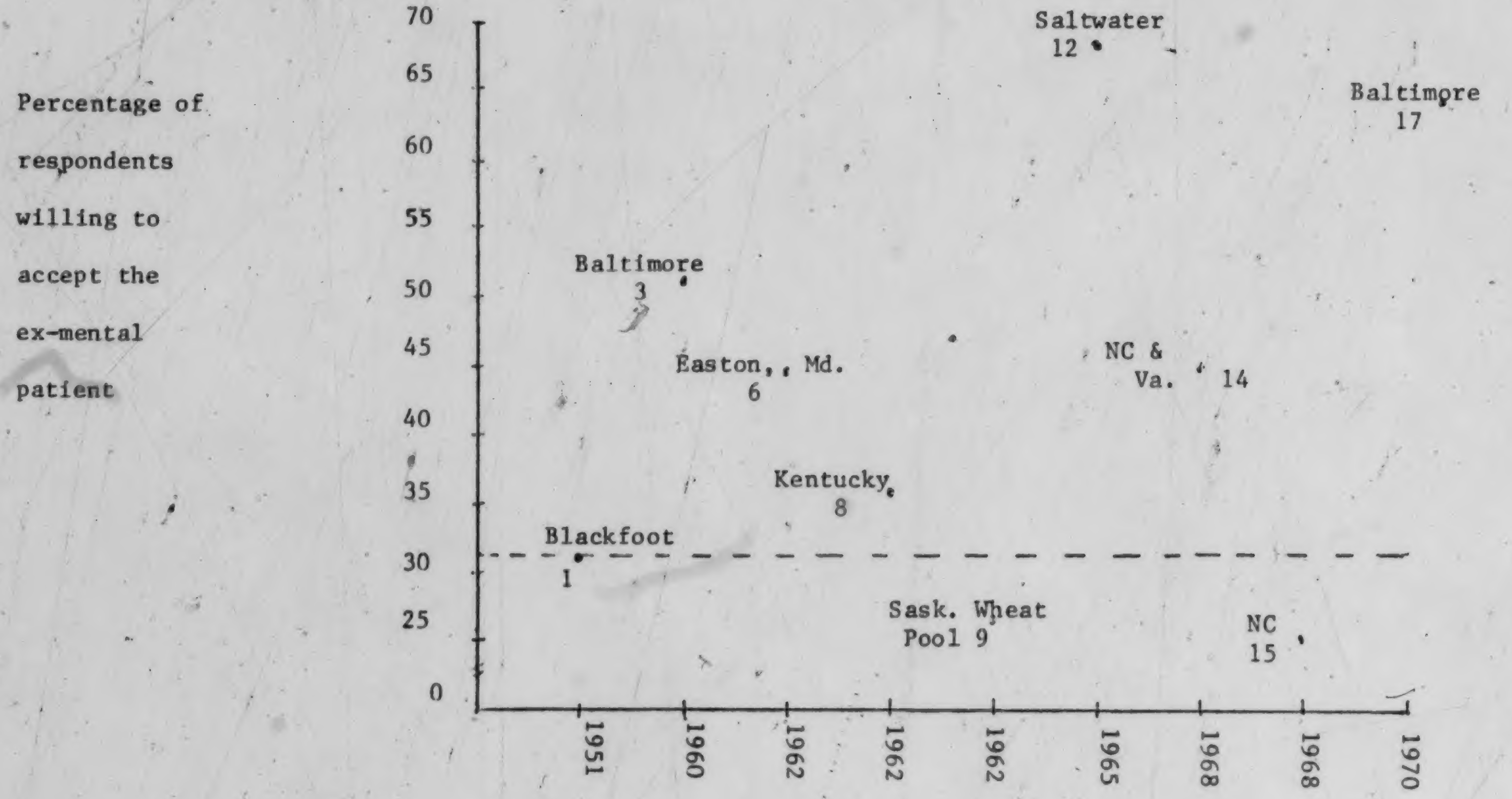
Acceptance of the ex-mental patient as a 'person for the respondent's children to marry' in eighteen study areas, 1951-1973.



* The number of the study corresponds to the number reported in Table 2.1.

Figure 2.2

Acceptance of the ex-mental patient as a 'person to fall in love with' in nine study areas, 1951-1970.



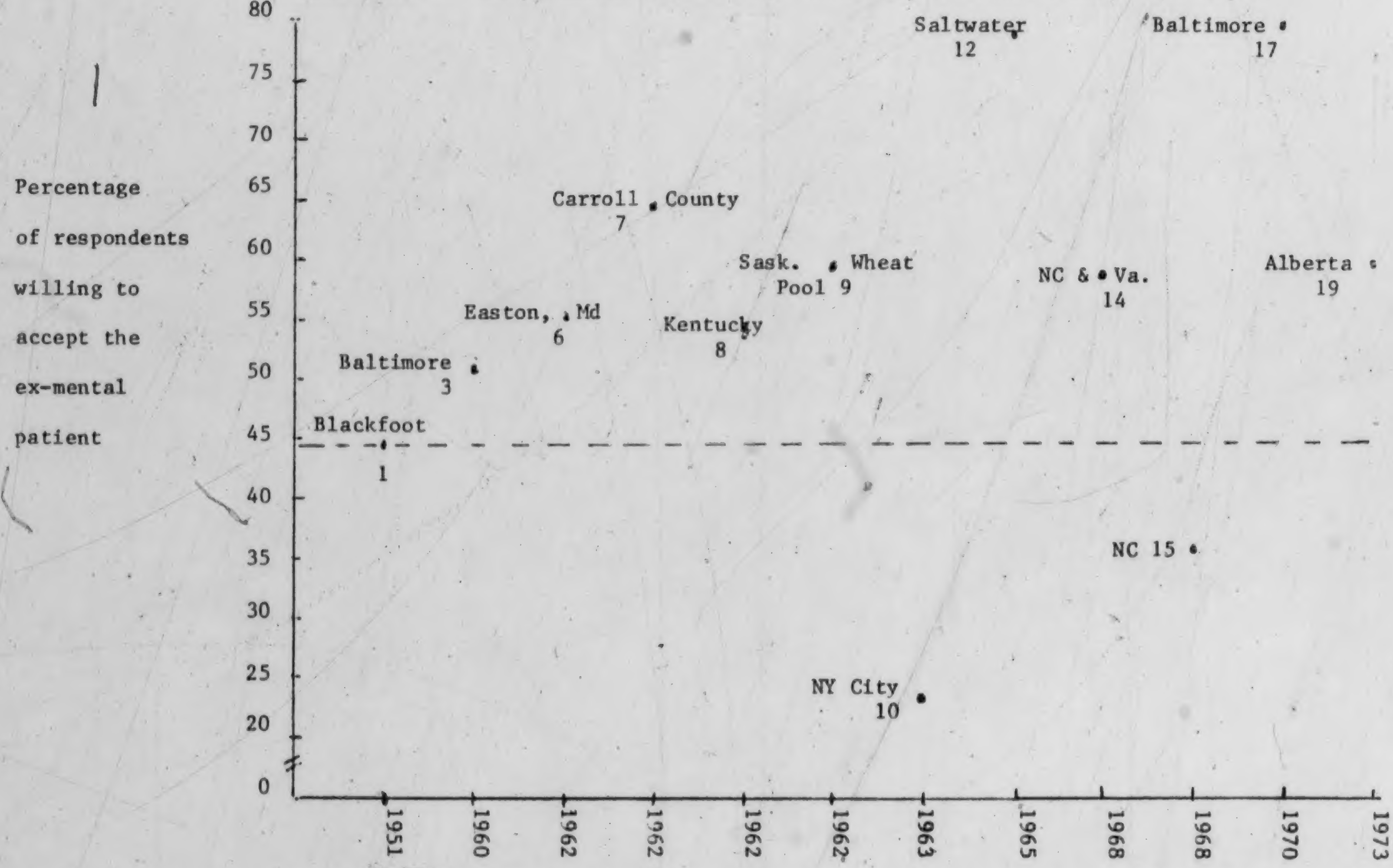


Figure 2.3

Acceptance of the ex-mental patient as a roommate in twelve areas, 1951-1973.

Figure 2.4

Acceptance of the ex-mental patient as tenant in an apartment, in six study areas, 1951-1970.

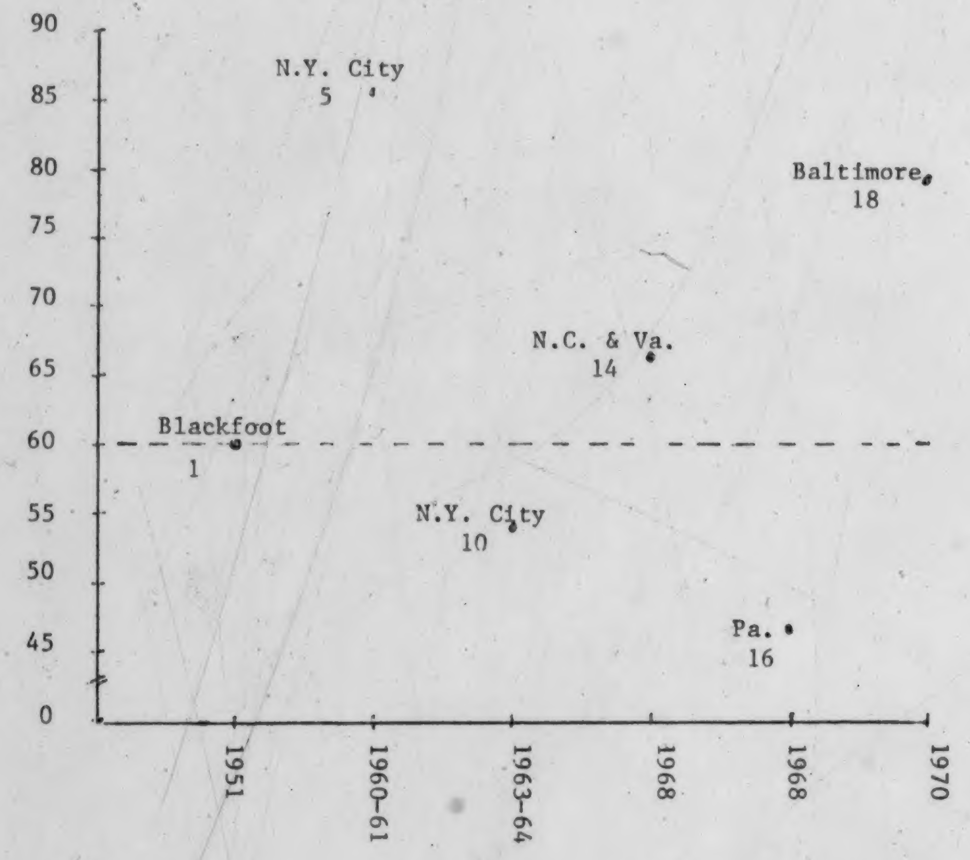


Figure 2.5

Acceptance of the ex-mental patient as workmate, in fifteen study areas, 1951-1973.

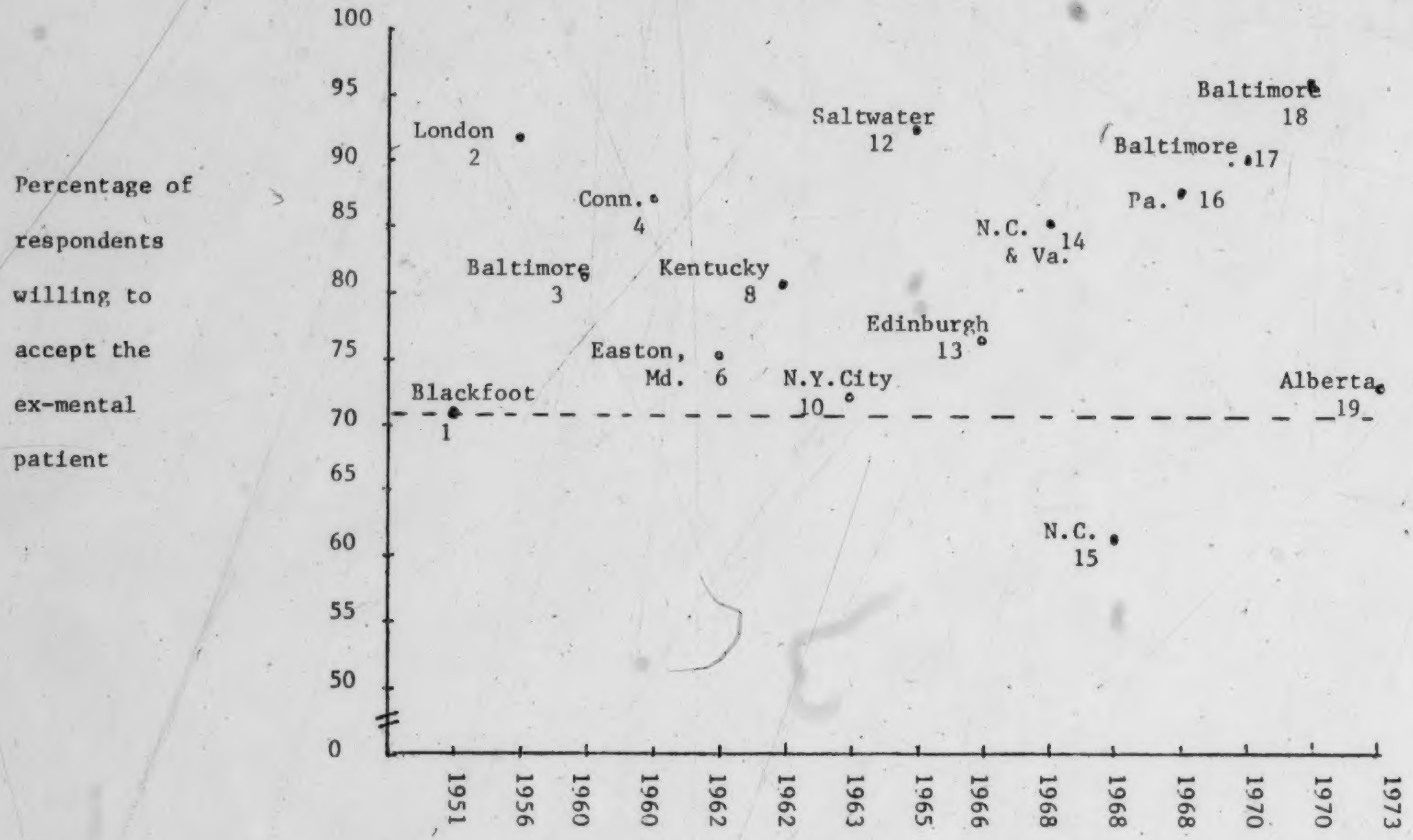


Figure 2.6

Willingness to sell an adjoining lot to an ex-mental patient, in four study areas, 1951-1968.

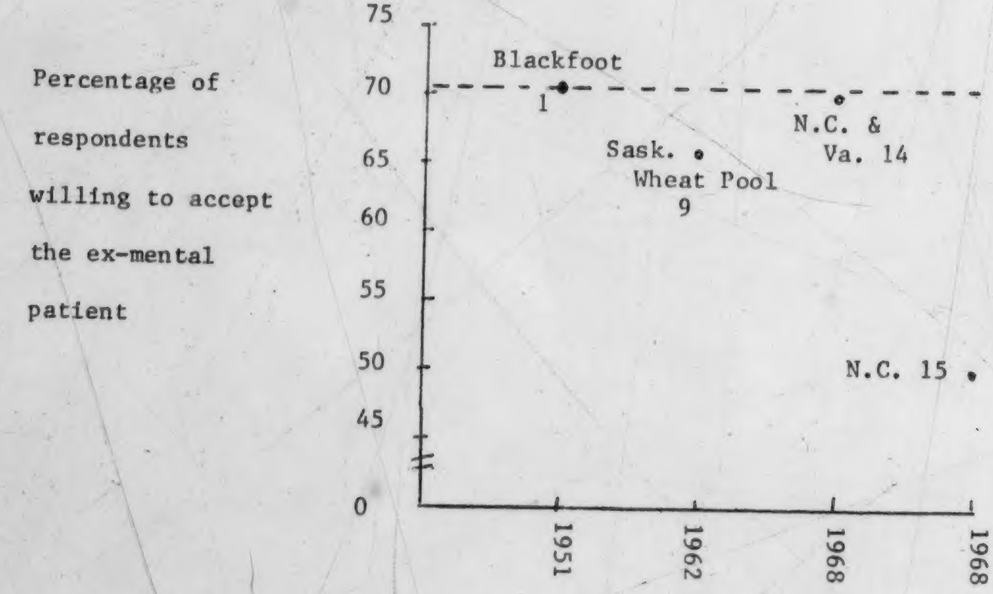
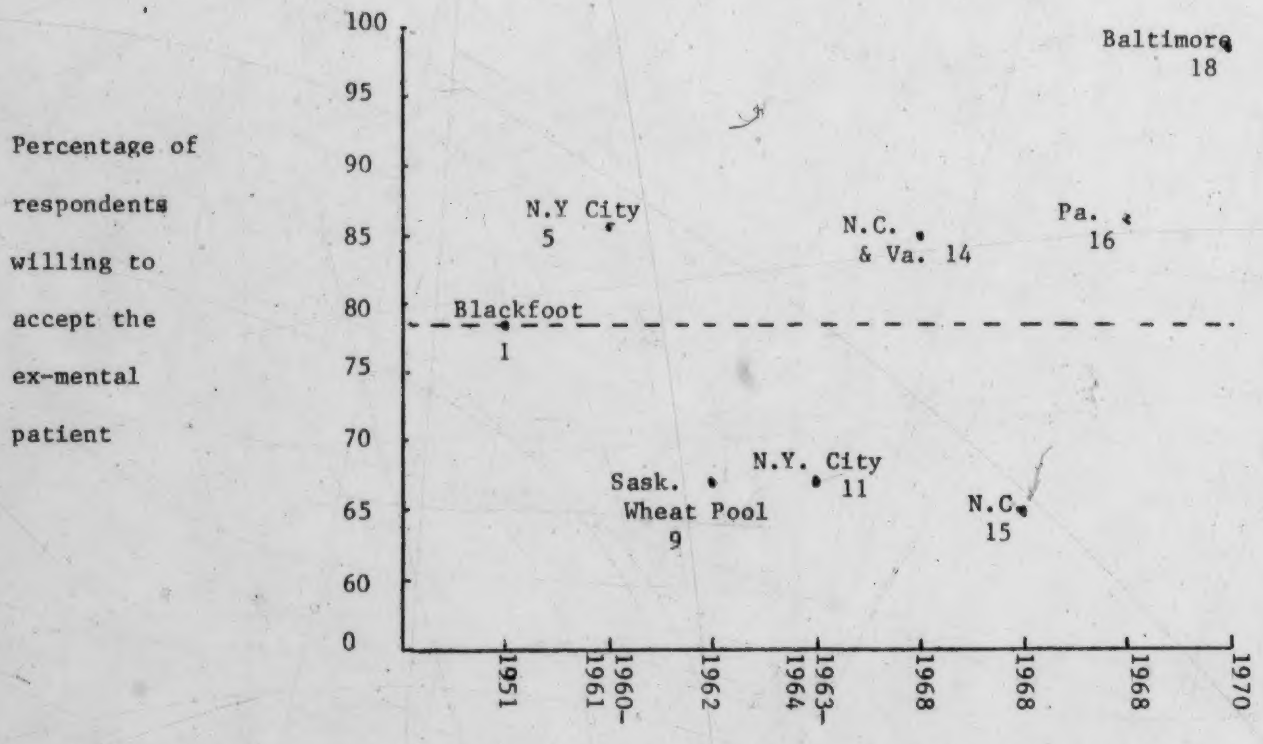


Figure 2.7

Willingness to sponsor an ex-mental patient in a club, in eight study areas, 1951-1970.



References

Allen, Lucile
1943 "Study of community attitudes toward mental hygiene." Mental Hygiene 27: 248-254.

Altrocchi, J. and C. Eisdorfer
1961 "Changes in attitudes toward mental illness." Mental Hygiene 45:563-570.

Badgley, Robin; Colin Smith and D.G. McKerracher
1966 "Studies of mental illness: The public." in D.G. McKerracher Trends in Psychiatric Care (Ottawa: Queen's Printer, 1966: 247-256).

Bates, Josephine
1968 "Attitudes toward mental illness." Mental Hygiene 52:250-253.

Bentz, Kenneth and Wilbert Edgerton
1970 "Consensus on attitudes toward mental illness." Archives of General Psychiatry 22: 468-473.

Bentz, W., W. Hollister and M. Kherlopian
1970 "Attitudes of social distance and social responsibility for mental illness: A comparison of teachers and the general public." Psychology in the Schools 7(2): 198-203.

Blizard, P.J.
1970 "The social rejection of the alcoholic and the mentally ill in New Zealand." Social Science and Medicine 4: 513-526.

Bord, Richard
1971 "Rejection of the mentally ill: Continuities and further developments." Social Problems 18 (4): 496-509.

Canter, F.M. and R. Shoemaker
1960 "The relationship between authoritarian attitudes and attitudes toward mental patients." Nursing Research 9: 39-41.

Chinsky, J. and J. Rappaport
1970 "Attitude change in college students and chronic patients: A dual perspective." Journal of Consulting and Clinical Psychology 35: 388-394.

Clark, A.W. ad Noel Binks
1966 "Relation of age and education to attitudes toward mental illness." Psychological Reports 19:649-650.

Clark, J.P. and L.L. Tifft
1966 "Polygraph and interview validation of self-reported deviant behavior." American Sociological Review 31:516-522.

Cohen, J. and E. Struening
1962 "Opinions about mental illness in the personnel of two large mental hospitals." Journal of Abnormal Social Psychology 64:349-360.

Crocetti, G.M. and P.V. Lemkau
1963 "Public opinions of psychiatric home care in an urban area." American Journal of Public Health 53:409-414.

1965 "On rejection of the mentally ill." American Sociological Review 30:577-588.

Crocetti, Guido; Herzl Spiro, Paul Lemkau, and Iradj Siassi
1972 "Multiple models and mental illness: A rejoinder to 'Failure of a moral enterprise: Attitudes of the public toward mental illness' by Sarbin and Mancuso." Journal of Consulting and Clinical Psychology 39(1):1-5.

Crocetti, Guido; Herzl Spiro and Iradj Siassi
1971 "Are the ranks closed? Attitudinal social distance and mental illness." American Journal of Psychiatry 127:1121-1127.

1974 _Contemporary Attitudes Toward Mental Illness._ University of Pittsburgh Press.

Crumpton, E., A.D. Weinstein, C.W. Acker and A.P. Annis
1967 "How patients and normals see the mental patient." Journal of Clinical Psychology 23:46-49.

Cumming, Margaret Elaine
1954 "The social control of mental illness, with special reference to the strategies of isoltion and denial." Unpublished doctoral disseration, Harvard University.

Cumming, Elaine and John Cumming
1957 _Closed Ranks: A Experiment in Mental Health Education._ Cambridge, Mass.: Harvard University Press.

Daniel, B
1962 "Discussion." American Journal of Psychiatry 118:

699-700.

D'Arcy, Carl
1974 "Decay or morphogenesis? On asylums and mental illness." A paper read to the Canadian Anthropology and Sociology Association Meeting. Toronto. August, 1974.

1975 "Opened ranks? Closed Ranks revisited." Research Document, mimeo. Research Unit, Psychiatric Research, University Hospital, Saskatoon.

D'Arcy, Carl and Joan Brockman
1975 "Changing public recognition of psychiatric symptoms? Blackfoot revisited." Manuscript. Applied Research Unit, Psychiatric Research, University Hospital, Saskatoon.

Decision Making Information Canada
1974 Perception of Mental Health The Citizens Point of View. A study commissioned by Alberta Health and Social Development.

Dillman, Don; James Christenson, Edwin Carpenter and Ralph Brooks
1974 "Increasing mail questionnare response: A four state comparison." American Sociological Review 39(October):744-756.

Dohrenwend, B.P., and E. Chin Shong
1967 "Social status and attitudes toward psychological disorder: The problem of tolerance of deviance." American Sociological Review 32:417-433.

Edgerton, J., Wilbert and W. Kenneth Bent,z
1969 "Attitudes and opinions of rural people about mental illness and program services." American Journal of Public Health 59:470-477.

Elinson, J., E. Padilla, and M.E. Perkins
1967 Public image of Mental Health Services. New York: Mental Health Materials Center.

Farnia, A., Donald Gliha, Louis Boudreau, Jon Allen and Mark Sherman
1971 "Mental illness and the impact of believing others know about it." Journal of Abnormal Psychology 77:1-5.

Farnia, A., J. Thaw, John Lovern and Dominck Mangone
1974 "People's reaction to a former mental patient moving into their neighborhood." Journal of Community Psychology 2(2): 108-112.

Floyd, Hugh and Paul Roman
1971 "Deviance and social rejection; stability and variation over time and space." Sociological Abstracts XIX(III):411.

Freeman, Howard E.
1961 "Attitudes toward mental illness among relatives of former - patients." American Sociological Review 26: 59-66.

Freeman, H. and O. Simmons
1963 *The Mental Patient Comes Home.* New York: Wiley.

Gelfand, S. and L.P. Ullman
1961 "Change in attitudes about mental illness associated with psychiatric clerkship training." International Journal of Social Psychiatry 7:292-298. aR3

Gurin, G., J. Veroff and S. Feld
1960 *Americans View Their Mental Health.* New York:Basic Books.

Hirschi, Travis and Hanan Selvin
1973 *Principles of Survey Analysis* New York: Free Press.

Hochstim, J.R.
1967 "A critical comparisn of three strategies of collecting data from households." Journal of American Statistical Association 62: 976-986.

Holtzberg, J.D. and H.A. Gerwirtz
1963 "A method of altering attitudes toward mental illness." Psychiatric Quarterly Supplement 37(1): 56-61.

Homes, D.
1968 "Changes in atttudes about mental illness." Center for Community Research. New York. (Mimeo.).

Johanssen, W.
1969 "Attitudes toward mental patients." Mental Hygiene 53: 218-228.

Johannsen, W.J., M.C. Redel and R.G. Engel
1964 "Personality and atttudinal changes during psychiatric nursing affiliation." Nursing Research 13(4): 343-345.

Joint Commission on Mental Illness and Health
1961 *Action for Mental Health.* New York: Basic Books.

Kahn, R.L.
1952 "A comparison of two methods of collecting data for social research: The fixed-alternative questionnaire and the open-ended interview." Unpublished Ph.D dissertation, University of Michigan.

Katz, D.
1942 "Do interviewers bias poll results." Public Opinion Quarterly 6:248-268.

Kentucky Mental Health Planning Commission
1964 Kentuckians' Attitudes Toward Mental Illness. Louisville, Ky.

Kirk, Stuart
1974 "The impact of labeling on rejection of the mentally ill: An experimental study." Journal of Health and Social Behavior 13:108-117.

Knudsen, D.D., H. Pope and D.P. Irish
1967 "Response differences to questions on sexual standards: An interview-questionnaire comparison." Public Opinion Quarterly 31:290-297.

Kolmer, M. and H. Kern
1968 "The resident in community psychiatry: An assessment of changes in knowledge and attitudes." American Journal of Psychiatry 125: 698-702.

Kulik, J., R. Martin and K. Scheibe
1969 "Effects of mental hosptial volunteer work on students' conceptions of mental illness." Journal of Clinical Psychology 25: 326-329.

Laine, Aira, and Ville Lehtinen
1973 "Attitudes toward mental illness and their relationship to social structure and mental hospital bed utilization in two Finnish rural communities." Social Psychiary 8(3): 117-123.

Lamy, R.E.
1966 "Social consequences of mental illness." Journal of Consulting Psychology 30: 450-455.

Lawton, M.
1964 "Correlates of the opinions about mental illness scale." Journal of Consulting Psychology 28(1): 94.

Lemkau, Paul and Guido Crocetti
1962 "An urban populations's opinion and knowledge

about mental illness." American Journal of Psychiatry. 118:692-700.

Lewis, I.L., and S.E. Cleveland
1966 "Nursing students' attitudinal changes following a psychiatric affiliation." Journal of Psychiatric Nursing 4(3): 223-231.

McGinnis, Robert
1953 "Scaling interview data." American Sociological Review October: 514.

MacLean, U.
1969 "Community attitudes to mental illness in Edinburgh." British Journal of Preventive and Social Medicine. 23:45-52.

Meyer, Jon K.
1964 "Attitudes toward mental illness in a Maryland community." Public Health Reports 79(September): 769-772.

Middleton, J.
1953 "The prejudices and opinions of mental hospital employees regarding mental illness." American Journal of Psychiarty 110: 113-138.

Mullins, Nicholas
1971 The Art of Theory: Construction and Use New York: Harper and Row.

Nettler, Gwynn
1970 Explanations. New York: McGraw-Hill.

Nunnally, J.C.
1961 Popular Conceptions of Mental Health: Their Development and Change. New York: Holt, Rinehart and Winston, Inc.

Phillips, Bernard S.
1971 Social Research - Strategy and Tactics. New York: MacMillan Company. @R3

Phillips, Derek L
"1963 "Rejection: a possible consequence of seeking help for mental disorders." American Sociological Review 28:963-972.

1964 "Rejection of the mentally ill: The influence of behavior and sex." American Sociological Review 29:679-686.

1966 "Public identification and acceptance of the mentally ill." American Journal of Public Health 56:755-763.

1967 "Identification of mental illness:Its consequences for rejection." Community Mental Health Journal 3(3): 262-264.

Pratt, Steve, Duilio Giannitrapani and Prabha Khanna
1960 "Attitudes toward the mental hospital and selected population characteristics." Journal of Clinical Psychology 16: 214-218.

Rabkin, Judith G.
1972 "Opinions about mental illness: A review of the Literature." Psychological Bulletin 77:153-171.

1974 "Public attitudes toward mental illness: A review of the literature." Schizophrenia Bulletin 10(Fall):9-33.

Ralph, D.E.
1968 "Attitudes toward mental illness among two groups of college students in a neuropsychiatric hospital setting." Journal of Consulting and Clinical Psychology 32:98.

Ramsey, G.V. and M. Seipp
1948 "Attitudes and opinions concerning mental illness." Psychiatric Quarterly 22: 428-444.

Ridenour, N.
1961 Mental Health in the United States: A Fifty-Year History. Cambridge: Harvard University Press.

Ring, Stephen and Lawrence Schein
1970 "Attitudes toward mental illness and the use of caretakers in a black community." American Journal of Orthopsychiatry 40:710-716.

Rootman, Irving
1972 "Social class and attitudes towards mental illness: A study of a Canadian praire community." Canadian Review of Sociology and and Anthropology 9(1): 21-32.

Rootman, Irving and Hugh Lafave
1969 "Are popular attitudes toward the mentally ill changing?" American Journal of Psychiatry 126:261-265.

Roper, Elmo & Assoc.
1950 "People's attitudes concerning mental health: A study made in the city of Louisville." For the city of Louisville and Colliers Magazine. September.

Rothman, David J.
1972 "Of prisons, asylums, and other decaying institutions." The Public Interest Winter: 3-17.

Rosenthal, Robert
1966 Experimental Effects in Behavioral Research. New York: Appleton-Century-Crofts.

Sarbin, T.R. and James C. Mancuso
1970 "Failure of a moral enterprise: Attitudes of the public toward mental illness." Journal of Consulting and Clinical Psychology 35(2) 159-172.

Saskatchewan Hospital Services Plan Covered Population
1974

Scott, R.D.
1973 "The treatment barrier: 1." British Journal of Medical Psychology 46(1): 45-55.

Smith, J.J.
1969 "Psychiatric hospital experience and attitudes toward mental illness." Journal of Consulting and Clinical Psychology 33: 302-306.

Star, Shirley
1952 "What the public thinks about mental health and mental illness." Unpublished paper presented to the annual meeting of the National Association for Mental Health, Inc., Indiana November 19.

1957 "The place of psychiatry in popular thinking." Unpublished paper presented to the annual meeting of the American Association for Public Opinion Research, Washington, D.C. May 9.

Sudman, Seymour and Norman M. Bradburn
1974 Response Effects in Surveys. Chicago: Aldine Publishing Co.

Swingle, P.
1965 "Relatives' concepts of mental patients." Mental Hygiene 49: 461-465.

Sydiaha, D.
1971 "An idiographic perspective in mission-oriented

research." The Canadian Psychologist 12(July):387-394.

Tershakovec, A.
1964 "An observation concerning changing attitudes toward mental illness." American Journal of Psychiatry 121: 353.

Thorndike, R.L., E. Hagen, and R.A. Kemper
1952 "Normative data obtained in the house to house administration of a psychosomatic inventory." Journal of Consulting Psychology 16:257-260.

Tringo, J.L.
1970 "The hierarchy of preference toward disability groups." Journal of Special Education 4:295-306.

Whatley
"Social attitudes toward discharged mental patients." Social Problems 6:313-320).

Williams
1964 "Interviewer-respondent interaction: A study of bias in the information interview." Sociometry 27:338-352.